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Frequently Asked Questions from “The Year Ahead: Outpatient Physical Therapy Coding and Reimbursement” Audio Conference held on December 5, 2006

Please note that since the audio conference took place, Congress passed legislation that retains the therapy cap exceptions process for calendar year 2007 and halts the 5% cut in the fee schedule by freezing the fee schedule payment update amount. In addition, CMS released three new transmittals that address the therapy exceptions process on December 29. Of note, beginning January 2007 CMS discontinued the manual exceptions process and expanded the diagnoses covered by the automatic process. CMS also provided some additional guidance concerning documentation. For more specifics on the transmittals, go to apta's website.

In order to avoid redundancy, below are direct links to the resources most frequently cited in this document:

Transmittal 36: <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf>

Transmittal 63: <http://www.cms.hhs.gov/transmittals/downloads/R63BP.pdf>

Transmittal 1145: <http://www.cms.hhs.gov/transmittals/downloads/R1145CP.pdf>

Transmittal 60: <http://www.cms.hhs.gov/transmittals/downloads/R60BP.pdf>

Plan of Care

Question: With regard to receiving the plan of care back from the physician: Is there acceptable documentation that would allow you to go ahead and bill Medicare without the plan of care? I have tried several times and several different ways to get the plan of care returned and have not succeeded. I am not clear on what documentation is required to justify a delayed certification.

Answer: The physician should be made aware of the Medicare provisions found in Transmittal 36 that require a physician to sign the plan of care developed by the physical therapist in order for the service to be covered. If the physician is still not willing to sign the plan of care, then the physician could develop his/her own plan of care for the patient. In addition, if the signed order from the physician includes the essential elements of the plan of care required in section 220.1.2 (diagnoses; long term treatment goals; and type, amount, duration and frequency of therapy services), that would be sufficient.

CMS does allow delayed certification if there is some information justifying the delay. CMS does not specify a time period for delayed certification. Documentation showing physician involvement, such as the order, telephone contact, or evidence of requests for certification would be important to have in the clinical documentation. The delayed certification of otherwise covered services should be accepted unless the contractor has reason to believe that there was no physician involvement in the patient's care, or treatment did not meet the patient's needs (and therefore, the certification was signed inappropriately).

CMS includes the following example in Transmittal 36 of a certification that was 2 years late:

“Example: Payment should not be denied, even when certified 2 years after treatment, when there is evidence that a physician approved needed treatment, such as an order, documentation of therapist/physician/NPP discussion of the plan, chart notes, meeting notes, requests for certification, or certifications for intervals before or after the service

in question.”

Question: Did I understand you correctly that no referral for PT is required for Medicare B as long as a signed plan of care is obtained within 30 days of the PT Evaluation? If I heard you correctly, when did this change take place and is there a reference I can show my employer?

Answer: Transmittal 36 eliminated the referral/order requirement. If your state law permits, patients can begin services without a referral/order. Patients must be under the care of a physician, and payment is based on a signed plan of care. Section 220.1.1 of CMS Transmittal 36, dated June 24, 2005, states:

An order (sometimes called a referral) for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician. However, the certification requirements are met when the physician certifies the plan of care. If the signed order includes a plan of care (see essential requirements of plan in §220.1.2), no further certification of the plan is required. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.

Question: On the physical therapy plan of care, is it acceptable to list number of visits over a set period of time (example: 10 visits in 4 weeks) instead of "times per week X number of weeks"? I work at a Senior Community Care Center (Pre-PACE program) and due to various circumstances it can be difficult to predict how many days per week a participant will realistically be available for therapy, due to other appointments. Some participants only attend from 10:30-1:30 three days per week, so writing "10 visits in 4 weeks" would allow more flexibility than "3 times per week for 4 weeks."

Answer: Section 220.1.2 of CMS Transmittal 60, issued on November 9 2006, explains the minimum requirements for a therapy plan of care. Under "Contents of Plan" the transmittal states that the plan of care shall contain, at a minimum, the diagnosis; long term treatment goals; and type, amount, duration and frequency of therapy services. "Frequency" refers to the number of times per week treatment is provided, and if not specified, one treatment is assumed. It is best to identify a specific number of times per week during which treatment should be provided. If there are absences, then the documentation should explain why the patient is absent on a particular day and therefore, the patient does not receive treatment at the frequency identified in the plan of care. Remember, the documentation requirements outlined in this transmittal are minimal. It would be prudent to include more information, such as short term goals, specific treatment interventions, procedures, modalities and the amount of each for more complete documentation.

Question: I have a question following the audio conference regarding advanced practice nurses. Does Medicare recognize their signatures on plan of care certifications and physician orders as a physician signature for physicians in practice with an advanced practice nurse? We have a building in which the advanced practice nurse comes in frequently to see patients for the physician that is our medical director. Are stamped signatures acceptable?

Answer: Medicare defines nonphysician practitioners as physician assistants, clinical nurse specialists, and nurse practitioners. If state and local laws permit it and appropriate rules are followed, they may provide, certify or supervise therapy services. This information can be found in the definitions sections of CMS transmittals 36 and 63.

Transmittal 63 defines a signature as a legible identifier of any type including hand written, electronic, or a signature stamp. Although stamped signatures are acceptable, providers should be aware that stamped signatures may be more vulnerable to abuse.

Question: Can a new referral from a physician to continue physical therapy count as their signature on the plan of care or does the signature have to be directly on the plan of care?

Answer: If the new referral has all of elements that a plan of care requires, then it could be considered as a certified plan of care. The required elements outlined in Section 220.1.2 of CMS Transmittal 60 are as follows: diagnosis; long term treatment goals; and type, amount, duration and frequency of therapy services. These elements are the minimal requirements. Ideally the plan of care would also include short term goals, specific treatment interventions, procedures, modalities, and the amount of each. If the physician's referral contains this much specificity, then it could be considered a certified plan of care. A physician may also reference the plan of care in other documents (e.g their order, physician progress notes) and that could constitute certification.

Question: If a physician fails to provide recertification, but writes orders for therapy within the specified time frames, is this acceptable as certification/recertification, assuming that the provider can demonstrate attempts to acquire the certification? When referring to the progress report/recertification, can this be used as the treatment plan review date and be one in the same as the plan of care?

Answer: The manual specifically states that you must have a certified plan of care for every 30 day episode of care. However, if the physician's order for therapy contains all the components of a plan of care (diagnoses; long term treatment goals; and type, amount, duration and frequency of therapy services), then it could satisfy the need for certification for that interval of treatment.

Question: Progress Reports do not require a physician signature unless the Progress Report is also serving as the plan of care. Is that correct? I also read that the Progress Report needs a signature if services are provided incident to a physician's care.

Answer: Progress Reports do not require a physician signature, however, according to Transmittal 63, the Progress Report can be used as supporting documentation for a plan of care. The transmittal states: *Although the Progress Report written by a therapist does not require a physician/NPP signature when written as a stand-alone document, the Plan of care accompanied by the Progress Report shall be re-certified by a physician/NPP.*

With respect to therapy services provided "incident to," the Progress Report should be written and signed by the therapist providing the services. Transmittal 63 states: *When a therapy service is provided by a therapist, supervised by a physician/NPP and billed incident to the services of the physician/NPP, the Progress Report shall be written and signed by the therapist who provides the services. However, if when the services incident to a physician are provided **by qualified personnel** who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.* The definition of qualified personnel includes an individual who is a graduate of physical therapist professional education program but is not licensed.

Question: Does every goal on the plan of care have to be functional?

Answer: The plan of care should clearly substantiate the existence of functional impairments and the need for physical therapy services to correct these impairments. The goals should therefore be related to improving the patient's function.

Question: Does cognitive level and rehabilitation potential need to be addressed on the plan of care?

Answer: If the patient has cognitive issues that may effect the duration of treatment, then these issues should be addressed in your clinical documentation. Transmittal 1145 lists conditions and complexities that may necessitate continuation of medically necessary services, including conditions that affect cognitive function. Concerning rehabilitation potential, this information would be reflected in the long and short term goals included in the plan of care.

Question: Do you also need to include short term goals along with the long term goals in your plan of care?

Answer: For Medicare payment purposes, you are required to include, at a minimum diagnosis, long term goals, and type, amount, duration and frequency of therapy services. However, clinicians may choose to make their plans more specific in accordance with good practice. They may include optional elements, such as short term goals.

Question: If a patient starts treatment on the 1st of the month and the physical therapist writes the plan of care on that day, the plan of care is good until the 30th. What if a patient goes out of town within the 30 day period, and comes back after 30 days has expired, is the PT required to write another plan of care to start the 30 day period again even if nothing has changed with the plan? Do we just keep writing a plan of care every 30 days even if a patient goes out of town?

Answer: The plan of care should be certified for the first 30 days of treatment and recertified every 30 days. The certification or recertification should be signed before, during, or within 30 days after the date first treated by the therapist. If the plan of care remains the same, it should still be recertified at the usual interval. Your clinical documentation should reflect any break in treatment.

With respect to absences, Transmittal 63 states the following:

Absences. Holidays, sick days or other patient absences may fall within the Progress Report Period. Days on which a patient does not encounter qualified professional or qualified personnel, for treatment, evaluation or re-evaluation, do not count as treatment days. However, absences do not affect the requirement for a Progress Report at least once during each certification interval. If the patient is absent unexpectedly at the end of the reporting period, when the clinician has not yet provided the required active participation during that reporting period, a Progress Report is still required, but without the clinician's active participation in treatment, the requirements of the Progress Report Period are incomplete.

For prolonged absences, you may want to consider discharging the patient. The medical necessity of continued care might be questionable in a patient who leaves town for prolonged periods of time.

Question: We have a question on matching the long term goal and the duration on the initial plan of care. If you anticipate it will take 8 weeks to achieve the long term goal, do you make the duration on the initial plan of care 8 weeks to match the long term goal and then 4 weeks on the second plan of care or, should the duration be 4 weeks on the first plan of care to match the 30 day interval and 4 weeks on the second plan of care to complete the treatment.

Answer: Transmittal 63 clarifies that long-term goals should be developed for the entire episode of care; not only for the services provided under a plan for one interval of care. The duration of the initial plan of care should coincide with the time frame for the plan of care.

Question: We utilize a form that has a patient progress report and recommendations for continuing therapy written by the therapist on the top part. There's a section at the bottom for the physician to comment, check off whether they would like us to continue therapy, if so, frequency and duration or if they want us to discharge, and then there's a place for their signature. Most of

the time, we receive these back with the physician signature only. Can we then assume that we are to continue therapy as the therapist recommended in the note?

Answer: Under the circumstances, it would seem reasonable to continue therapy, as per the therapist's recommendation, since the physician has had an opportunity to give feedback. If you want further clarification, a telephone call to the physician may be a good idea.

Question: Could you please clarify the definition of "interval of treatment?"

Answer: Transmittal 63 defines an "Interval" of treatment to mean 1 month or 30 calendar days, whichever is more. An "Episode" refers to the period of time, in calendar days, from the first day the patient is under the care of a clinician until the last date of service.

Discharge Notes

Question: Can the 10 visit Progress Report also serve as a recertification or discharge summary?

Answer: The recertification requirement relates to the plan of care being reviewed and signed off by a physician. The Progress Report can be submitted with a plan of care, but does not take the place of the plan of care.

A Discharge Note is required for each episode of treatment. Transmittal 63 states the following with respect to Discharge Notes: *The Discharge Note shall be a Progress Report written by a clinician, and shall cover the reporting period from the last Progress Report to the date of discharge... Clinicians should consider the discharge note the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed.*

Diagnosis

Question: Concerning referrals from a doctor, if a doctor doesn't specify the diagnosis on the referral, the PT writes it on the plan of care for the doctor to sign, is that correct? Sometimes what the physician writes on the original order is not specific enough.

Answer: You should evaluate the patient and identify the condition for which you are treating them. Often, the physical therapy diagnosis will be different from the physician's because it is based on the patient's functional impairment.

Question: Is "vertigo" or "BPPV" an acceptable diagnosis for Medicare reimbursement?

Answer: Check your Medicare contractor's Local Coverage Determination (LCD) for information about whether treatment for these diagnoses are covered services. Since no National Coverage Determination (NCD) exists for vestibular conditions, Medicare contractors have the discretion to determine what they will cover. Your LCD should provide this information. You can find the link to your contractor's policy at: http://www.cms.hhs.gov/mcd/index_lmrp_bystate.asp

The list of diagnoses that qualify for an automatic exception found in Transmittal 1145 contains "vertiginous syndromes and other disorders of vestibular system." Therefore, if you have a patient with this diagnosis and your local contractor covers this treatment and services are medically necessary beyond the cap, these services will be covered.

Evaluation

Question: If a patient brings in a legible or typed information sheet for medical history or medications can you write "see attached" on the Evaluation form as long as you, the therapist, review it with the patient and sign and date it?

Answer: You could reference the attached document. However, if you are referencing it, the attached document should be easily accessible and readily available along with your evaluation.

Question: Can you address the patient's activities such as golf, tennis, or knitting as functional goals if these activities were part of the patient's prior level of function?

Answer: The return to golf, tennis or knitting, are not functional goals. The therapist could state in the clinical documentation that "returning to tennis" is one of the patient's goals, along with other activities of daily living, however. The therapist should identify the functional impairments that can be addressed through medically necessary physical therapy services, and write the goals accordingly. For example, goals for the patient could be that they attain a certain range of motion, walk a specific distance, or lift a specific amount of weight, without pain, within a certain amount of time. Reaching these functional goals may also allow the patient to resume certain leisure activities, in addition to improving their overall function.

If a patient seeks physical therapy only to improve his/her golf or tennis swing, independent of any medical condition that requires physical therapy, this type of service would not meet the Medicare requirement of being reasonable and necessary and would therefore not be covered services.

Billing Medicare

Question: Is there any limitation as to the onset date put on the initial evaluation during the evaluation? For example, if the onset date is over one year ago will or can Medicare deny physical therapy services because the patient has not needed physical therapy services before during that year. Does there need to be an exacerbation of a chronic problem for it to be covered?

Answer: Many Medicare beneficiaries have chronic conditions that require occasional physical therapy due to an acute exacerbation of symptoms, resulting in a loss of function. As with any other patient, in order to justify the medical necessity of your services, it would be important to note the loss of function that brought the patient to physical therapy. Your plan of care should address your findings from the evaluation. If you meet Medicare's medical necessity and documentation requirements, you should be reimbursed for services to patients with an acute exacerbation of a pre-existing condition.

Further, Transmittal 63 suggests that documentation supporting medical care prior to the current episode be included in the patient record. This would include whether the patient has previously been treated for the same condition.

Question: We are an outpatient physical therapy clinic operating in an office setting, how do we bill for items such as ankle braces, splints, elbow braces, etc?

Answer: Currently, if you are a physical therapist in private practice and want to bill the Medicare program for these items, you must obtain an NSC supplier number. The items are then billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), formerly known as a Durable Medical Equipment Regional Contractor (DMERC), using the appropriate L code. To obtain a supplier number, contact the National Supplier Clearinghouse, Palmetto, GBA (<http://www.palmettogba.com/>)

The DMEPOS program in Medicare is currently transitioning to a competitive acquisition system and many changes are underway. Watch the APTA website and weekly PTBulletin Online for further information as it develops.

Question: What is meant by "bundling services?"

Answer: When one service or modality is considered part of another service, and not separately payable, then those services are considered "bundled" services. A good example is the application of hot or cold packs. Medicare considers these services to be bundled with other physical therapy services, and therefore not separately payable.

Question: We have a Medicare patient that is also involved in a Workers' Compensation case. He's having a hard time getting authorization from the Workers' Compensation adjustor and was wondering if he can use his Medicare benefits for now. Can he?

Answer: Medicare is secondary to workers compensation if payment has been made or can reasonable be expected to be made. Under certain circumstances, Medicare may make conditional payments, subject to reimbursement, if the WC has not paid or will not pay promptly.

Where there is an indication that WC may pay for the services, the provider bills the WC carrier. If WC pays for all of the services (whether at the provider's customary charge rate or at a special WC rate) the provider submits a Medicare bill indicating the insurer paid in full. The beneficiary's Medicare deductible will be credited, however no payment will be made.

If the provider's WC claim is denied, the provider determines whether any other MSP provisions apply and bills accordingly. If no other primary payers are available, the provider submits:

- A bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in FL 36; and
- A supplementary statement calling attention to the fact that WC has denied payment or annotates FL 84, remarks, with the reason.

Question: It is my understanding, or perhaps my misunderstanding, that you can't bill for more than one unit of therapeutic exercise, and that you also can't bill for therapeutic exercise and functional activities at the same time. Is this true?

Answer: Therapeutic exercise, CPT 97110, is a timed code, and therefore payment is based on 15 minute units of service. You may therefore bill more than one unit if your documentation supports the services you have provided.

The Correct Coding Initiative (CCI) prohibits certain codes from being billed on the same date of service. For many of these code pairs, you may append the -59 modifier to indicate that the services were performed during separate time intervals. Overuse of the -59 modifier should be avoided, however. For more information on the CCI edits, visit the Medicare Coding and Billing area of the APTA website.

Question: Does the Medicare claim need to reflect that the treatment was performed by a physical therapist assistant rather than a PT? If so, how is that indicated?

Answer: No, the claim does not need to indicate that a physical therapist assistant was involved in the treatment. However, the clinical documentation should clearly reflect when a physical therapist assistant was involved in the delivery of services.

Therapy Cap

Question: When a patient has an ICD-9 code indicating an automatic exception to the therapy cap, and you expect to exceed the cap for that patient, at what point do you begin adding the KX modifier? Do you start using this modifier at the first visit? Or do you wait until they are near the cap?

Answer: In most cases, it would be advisable to wait until the patient is close to exceeding the cap before using the KX modifier. The KX modifier is your attestation that the patient requires additional medically necessary physical therapy treatment. You should track the amount of money applied toward the patient's cap, and if you find that they continue to need services as they get close to the cap amount, apply the KX modifier at this time.

Question: I cannot find the area on the APTA website which states that timed procedures should be treated the same for Medicare and non-Medicare payers.

Answer: This issue relates to the Common Procedural Terminology (CPT) codes themselves, not the payer. The 97000 series of codes, the most commonly used CPT codes for physical therapy services, are either timed by 15 minute units, or untimed. Untimed codes, such as the evaluation code (97001) or the Group Therapeutic Procedures code (97150) can be reported only once per visit. Visit the Reimbursement area of the APTA website to find additional information on CPT coding changes that take place annually and other information about the code set.

Question: What are Medicare patients supposed to do if they live in a rural area and don't have a local hospital that provides PT once they have reached the \$1780.00 cap?

Answer: Congress passed legislation in December 2006 that extends the exceptions process for 2007. Therefore, the patient may qualify for an exception. Transmittal 1145 clarifies that "lack of access to outpatient hospital therapy services alone does not justify excepted services... The patient's condition and complexities might justify extended services, but their location does not." In other words, if the patient requires medically necessary services beyond the cap, then they should continue to receive them. It is very important that the clinical documentation justify the patient's need for additional services.

Question: When submitting claims with the KX modifier, do we submit documentation at the same time? If so, how do we submit that documentation? We will be using a clearinghouse to submit claims.

Answer: There is no need to submit the documentation with the claim. Use of the KX modifier serves as an attestation of the need for physical therapy services beyond the therapy cap amount. Your documentation should support the medical necessity of these services, in accordance with the guidelines found in Transmittal 63, however, you do not need to submit this documentation unless you receive a request for additional documentation from your Medicare contractor.

Question: When multiple modifiers are needed (ex. KX, GP, 59) is there a correct order to list them?

Answer: CMS has confirmed that the order of the modifiers on the claim does not matter. However, it would be advisable to check with your Medicare contractor to see if they have any requirements that might be more specific.

Question: Assuming there is no exceptions process in 2007 can patients who have reached the maximum of their physical therapy cap be transferred to an occupational therapist if the diagnosis is within their scope of practice and they require more therapy?

Answer: When APTA held the audio conference in December, it was not known if Congress would act to extend the therapy cap exceptions process. Before they adjourned, however, Congress did pass the Tax Relief and Health Care Act of 2006. This legislation extended the exceptions process into 2007.

To further answer your question, if a patient's diagnosis is within the scope of practice of an occupational therapist and the occupational therapist is meeting all other Medicare requirements then that patient could see an occupational therapist for treatment. Had the therapy cap been fully implemented for 2007, patients would have had a shared \$1780 therapy cap for physical therapy and speech-language pathology services, and occupational therapy services would have had a separate \$1780 cap.

Question: I work at a rural hospital with an attached nursing home. If we transport a patient from the nursing home to the hospital and register them as an outpatient are they exempt from the cap?

Answer: Patients who are residents in a Medicare certified part of a skilled nursing facility (SNF) may not utilize outpatient hospital services for therapy services over the financial limits, because consolidated billing rules require all services to be billed by the SNF. The SNF would have to discharge the patient in order for the patient to receive services from the hospital. However, when therapy cap exceptions apply, SNF residents may qualify for exceptions that allow billing within the consolidated billing rules.

Question: If a patient meets his/her Medicare Cap, and presents a couple months later with a *different* condition, is it considered automatically excepted?

Answer: In cases where the services are appropriate and medically necessary, treatment during the same year for different conditions would be an exception from the therapy cap.

Question: If a patient goes to a hospital-based outpatient clinic for 8 visits and then they come to a physical therapy clinic, does the money amount they accrued at the hospital clinic apply toward the cap or are we starting at a zero balance since they have only been to a hospital outpatient clinic thus far?

Answer: You would be starting at a zero balance because none of the visits from the hospital outpatient department are captured in the Common Working File, and therefore would not accrue toward the therapy cap.

Question: Does the cap apply to Medicaid patients or just Medicare patients? Does this vary by state?

Answer: The therapy cap only applies to Medicare beneficiaries, though state Medicaid programs can also place limits on the amount of physical therapy beneficiaries can receive. The type and amount of services covered by Medicaid vary extensively depending on the state. The Medicaid program is a federal-state partnership, and therefore administration of the program can vary greatly.

Students

Question: Can you clarify the degree to which a physical therapy student can participate with patient care, as it relates to reimbursement? Also, please clarify any differences in the care setting.

Answer: Services performed by a student are not reimbursed under Medicare Part B. Medicare pays for services of physicians and practitioners authorized by statute. Students do not meet the definition of practitioners listed in §1861 of the Social Security Act.

Only the services of the therapist can be billed to Medicare and paid. However, the fact that the student is "in the room" would not make the service unbillable. The student can participate in the delivery of services when a physical therapist is directing the service, making the skilled judgments, and is responsible for the assessment and treatment.

For further information on the student requirements with respect to each of the treatment settings, go to the Medicare area of APTA's website (apta.org) and look for the "[Student Supervision and Medicare](#)" chart under the heading of "Assistants, Aides and Students."

Physical Therapist Assistants

Question: Have the rules, regulations or responsibilities involving physical therapist assistant duties changed at all?

Answer: The qualifications and responsibilities of physical therapist assistants can be found in the Medicare manual, and there have been no major revisions in recent years. Transmittal 36 defines physical therapist assistants in Section 230 (C) "Services of Physical Therapy Support Personnel."

Question: We have combined our Progress Note with our plan of care. We had a patient that was seen by the physical therapist assistant for 3 visits past the certification period. The physical therapist did not actively participate in any of the 3 visits and was not able to treat/assess the patient until after the 3 visits, but concluded that skilled therapy was needed past the certification time. We deleted those 3 visits from the patient's charge account. Was that necessary?

Answer: With respect to delayed active participation, Transmittal 63 states that if the Progress Report has not been written before the end of the Progress Reporting Period, it must be written within 7 calendar days. If the clinician did not actively participate in the patient's treatment during the Progress Report Period, documentation of the delayed active participation should be entered into the Treatment Note as soon as possible and explain the reason for the missed active participation. In addition, the Treatment Note should document the clinician's guidance to the assistant to justify that the skills of a therapist were required during the reporting period. The contractor shall then make a clinical judgment about whether the continued treatment by the assistant was reasonable and necessary.

Documentation

Question: Can the time reviewing the chart before treatment and later documenting the daily treatment be included in the total treatment time?

Answer: No. Only the time spent in active treatment counts toward total treatment time.

Question: Are there published documentation forms that you could recommend that are available to purchase for use by PT's that will cover all the necessary documentation requirements? We thought if there was already something in existence, there would be no need to reinvent the wheel.

Answer: APTA has resources available to assist members with documentation requirements. The Medicare, Practice Management, and Reimbursement sections of the APTA website have helpful information on documentation issues. You can also order APTA's *Coding, Compliance and Reimbursement for Physical Therapists* by calling 800-999-2782x3395.

Question: Currently we lease pool space outside of our physical PT office for our aquatic program. We are a part B Medicare provider in a physical therapist owned practice. We provide one-on-one aquatic therapy for Medicare patients in the pool. Are we required to lease the entire pool (Olympic size) during the time we treat Medicare patients, or can we have a designated section of the pool during our session with the Medicare patient?

Answer: Transmittal 36 addresses the definition of private practice, and within this definition, discusses aquatic therapy specifically, stating:

...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.

Currently there are no provisions that would allow you to lease a portion of the pool. You should also check with your Medicare contractor for their interpretation of the language.

Question: Can you provide me with additional information on the "8 Minute Rule?"

Answer: CMS Transmittal 1019, dated August 3, 2006, will provide you with additional clarification. Transmittal 1019 is available on APTA's website or at: <http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf>.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one-on-one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units can be billed. Time intervals for larger numbers of units are as follows:

Units Reported on the Claim Number Minutes

3 units > 38 minutes to < 53 minutes

4 units > 53 minutes to < 68 minutes

5 units > 68 minutes to < 83 minutes

6 units > 83 minutes to < 98 minutes

7 units > 98 minutes to < 113 minutes

8 units > 113 minutes to < 128 minutes