

## Frequently Asked Questions From the APTA Audio Conference

### “Medicare Payment Policies for Outpatient Physical Therapy: Mastering the Rules”

September 14, 2006

#### **OCCURRENCE CODES REGARDING THE THERAPY PLAN OF CARE**

**Question:** *Did I understand correctly that the requirement to add in the date the plan of care was established/reviewed (occurrence codes 17, 29, and 30) on the UB 92 is going away? I tried to find this information on the CMS website with no luck. Can you point me in the right direction?*

**Answer:** Yes. Effective October 2006, CMS is removing the language regarding these occurrence codes from its Claims Processing Manuals (100-04), chapter 5, section 20- HCPCS coding requirements (<http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf>) In October 2006, the lines below will be removed from this section of the manual:

“Providers billing to intermediaries shall report:

- The date the therapy plan of care was either established or last reviewed (see §220.1.3B) in Occurrence Code 17, 29, or 30.
- The first day of treatment in Occurrence Code 35, 44, or 45.”

This change was made by Transmittal 980, which is available on CMS’s website at <http://www.cms.hhs.gov/transmittals/downloads/R980CP.pdf>

When you read the Transmittal 980 you will not see an affirmative statement regarding the removal of these occurrence codes. However, APTA has confirmed with CMS that they will be removed based on this Transmittal.

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**Question:** *Is the “date last reviewed” when the therapist completes the plan of care (either cert or re-cert) or when the doc signs it?*

**Answer:** We recommend checking with your intermediary to determine the date that they consider “date last reviewed.” Most likely, it would be the date the therapist completes the plan of care.

## **CERTIFICATION / PLAN OF CARE and ORDERS**

**Question:** *We presently have a physician that refuses to sign the plan the care; he states that he does not want to sign anything that is not his own examination. He has been informed that it is a requirement that the Medicare POC be signed, but he still refuses. Do you have any suggestions?*

**Answer:** First, I would recommend that you show the physician the sections of the Manuals (Transmittal 3648) that require that the physician sign the plan of care if it is developed by the physical therapist in order for the service to be paid and covered. If the physician is still unwilling to sign the plan of care, then the physician could develop his/her own plan of care for the patient. As another option, if the signed order from the physician includes the essential elements of the plan of care a 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.

**Question:** *Sometimes what the physician writes on the original order is not specific enough. For instance, the physician just writes "malunion right hip fracture" on his order but the therapist is actually treating for hip pain. In this case would we have to go back to the physician for further clarification of the original diagnosis, or can we bill with the hip pain diagnosis which is what the patient is being treated for and is on the plan of care?*

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

**Question:** *The 30 day recertification has sometimes been stated as 60 days for the initial 60 days of care with 30 day recertification after that. Or is it 30 days initially and each 30 days after that. AND when is the exact starting point for that 30 or 60 days? Is it the day they see referring physician or does it begin the day physical therapy is initiated?*

**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. For specific information regarding recertification, go to Transmittal 3648 (go to section 220.1.3) which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf>

**Question:** *I know that a Medicare recertification, or updated plan of care, must be completed by the PT every 30 days while receiving skilled part B services. What is the right way to handle an unexpected break in service - for example: patient is evaluated Aug. 1 and initial POC is completed, pt. is seen by PTA for treatments 8/3-25, patient unexpectedly gets a cold - or for other unplanned reason cannot get to outpatient PT during the week of 8/28 when the RPT plans are beyond the 30 day window. In this case - should the RPT do a recert on 9/5 that will be 6 days late? or, should the RPT write up a recert in collaboration with the PTA that can be completed on or before the 30 day due date?*

**Answer:**

A progress report must be completed at least once during each Progress Report period. If the patient is absent unexpectedly as described in your scenario, I would recommend that you check with your contractor on their policy. It would be advisable for the clinician to write a progress Report within one week of the end of the reporting period using any available information, explaining the reason for the missed visit and documenting the clinicians involvement and guidance during the reporting period. As soon as possible, the visit and an updated Progress Report should be put into the record. Your contractor will make a clinical judgment whether skilled therapy is needed and therefore continued treatment is appropriate and whether the

therapist has taken an active part in the treatment. Judgment will be based on each case, so it is important to document the guidance of the therapist during the course of treatment.

**Question:** *In regards to Progress Reports, if you are documenting in your daily notes progress towards the goals outlined in the Plan of Care via ROM and strength measurements, functional abilities, etc. are you required to still write a separate Progress Report every 30 days or after 10 treatments? (I know that a re-certification of the Plan of Care of course has to happen every 30 days regardless.)*

**Answer:** Elements of *Progress Reports* may be written in the *Treatment Notes* daily 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.

**Question:** *In reference to delayed certification, if you have been unable to ascertain a signed plan of care from the physician in the first 30 days, and you have documentation that you have attempted, how do you comply with the "delayed certification" requirements to continue to see the patient? The delayed certification has such a broad base of allowed situations, should there be a time period that the patient be terminated if no signature for initial plan of care or recertification(s) are signed?*

**Answer:** CMS does not set forth a time period to terminate the patient if there is no signature. CMS does allow delayed certification if there is some information justifying the delay. For example, the physician may have lost the plan of care. Documentation showing physician involvement, such as the order, progress notes, telephone contact, requests for certification, would be important in this instance. The delayed certification of otherwise covered services should be accepted unless the contractor has reason to believe that there was no physician involved in the patient's care, or treatment did not meet the patient's need (and therefore, the certification was signed inappropriately).

CMS includes the following example in Transmittal 3648 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."

Information on delayed certification is included in Transmittal 3648 which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf#search=%22Transmittal%203648%22>

**Question:** *Regarding certification dates-does the 30day interval need to be notated on the certification sent to the doctor (ex: 10-13-2006 to 11-12-2006) or is that something that is not required to be written out (understanding that the patient would still need a recertification completed at the end of each 30day period)?*

**Answer:** The plan of care should include the signature and professional identity (e.g., MD, PT) of the person who established the plan, and the date it was established must be recorded the plan. Establishing the plan is not the same as certifying the plan. There is not requirement that you include the beginning and ending date of the 30 day interval in the plan of care. The physician should review and sign and date the plan of care.

**Question:** *long the same line with certification dates/periods-are the 30days consecutive (meaning 10-13-2006 to 11-12-2006 and then recert 11-12-2006 to 12-12-2006) or does each 30day recertification period begin from the first pt visit outside of the previous certification period*

*(if pt seen 11-11-2006 then 11-14-2006 would the cert dates be initially 10-13-2006 to 11-12-2006 and then 11-14-2006 to 12-14-2006)?*

**Answer:** The plan of care should be certified for the first 30 calendar 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. In the example given, the first period would be 10-13-2006-11-11-2006 and the next would begin 11-12-2006 to 12-11-2006. For specific information regarding recertification, go to Transmittal 3648 (go to section 220.1.3) which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf>

**Question:** *Do I have to have the Plan of Care signed every 30 days if Medicare is a secondary payor?*

**Answer:** The answer depends. In general, if Medicare is going to pay for a service, they would require that the requirements for reimbursement under the Medicare program, such as the 30 day certification requirement be met. Thus, it would be advisable if you think that Medicare might end up paying that you get the certification. If Medicare is secondary and most likely will not be paying, then you would follow the policies of whoever the third party payor is.

**Question:** *Can you please clarify the LAST MD DATE SEEN requirements? Is this the date the patient was last seen by the MD when I receive the initial referral, ie the date the referral was written? Because the client may just go by the MD office to retrieve the paper referral and does not have a scheduled paying appointment with the MD.*

**Answer:** Effective June 2006, the requirement that the patient go to the physician for an office visit was eliminated. See Transmittal 3648 at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf> . CMS deleted the requirement that the date last seen by a physician be entered on the 1500 claim form due to the change in policy made in CR 3648. The deletion of the date last seen requirement was made by Transmittal 980, which is available on CMS's website at <http://www.cms.hhs.gov/transmittals/downloads/R980CP.pdf> The effective date of Transmittal 980 is October 2, 2006. In the meantime, I recommend that you check with your contractor to determine the date they want you to include (prior to October 2, 2006) in box 19.

**Question:** *During the continued episode of care, is the patient required to be seen by the referring MD every 30 days or is 60 days adequate for the next certification period following the initial consultation? Who is responsible for gathering this date? Do I have the client self report or must this be confirmed by the MD office in writing?*

**Answer:** Effective June 2006, the requirement that the patient go to the physician for an office visit was eliminated. See Transmittal 3648 at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf> The requirement is that the physician review and sign the plan of care. However, the physician could require in his or her order that there be an office visit.

**Question:** *Can you clarify the certification periods? Is it always 30 days/1 month or the initial being 60 days following the initial consultation visit?*

**Answer:** The plan of care should be certified for the first 30 calendar days/ 1 month 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. See Transmittal 3648 at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf>

**Question:** *In a physician owned PT clinic, if the physical therapist evaluates a mc patient referred by an outside physician-does the certification have to signed by the referring physician if the*

*clinic's physician has not yet seen the patient for the referred symptom (or can the physician who operates the physical therapy clinic sign the certification written by the physical therapist even if the patient has not been evaluated by that physician?)*

**Answer:** The answer to your questions depends on how the services are being billed. If the services are being billed as "incident to" the physician's professional services, then the physician whose billing number is being used must first see the patient before sending the patient for physical therapy. If the services are being billed under a number of the physical therapist in private practice, then it is possible that the physician signing the plan of care could be a different physician outside the practice.

**Question:** *When does the re-certification period begin for hospital based outpatient physical & occupational therapy? Does the re-certification period begin when the 701 form was completed and dated or does it start with the date shown in the certification period box on the form?*

**Answer:** Recertification would be required 30 days after the patient's first therapy encounter.

### **ADVANCED BENEFICIARY NOTICE/NOTICE OF EXCLUSION OF MEDICARE BENEFITS**

**Question:** *We have an outside billing company who wants us to have all Medicare patients sign the ABN at the time of their first visit. We have disagreed with this policy due to the parameters we have heard and read. Could you please define this clearly?*

**Answer:** It would be inappropriate to have all Medicare patients sign the ABN at the time of their first visit. That would be considered routinely giving ABNs, which would be a prohibited practice. The only circumstance where it would be permissible would be when there is an NCD or an LCD in effect that you know clearly states that a particular service you are providing is not covered under Medicare. For example, there is an NCD stating that electrical stimulation for the treatment of Facial Nerve Paralysis is not covered. Therefore, it would be appropriate to give an ABN to all patients who you are treating for Facial Nerve Paralysis using electrical stimulation. Information is available in the Medicare Claims Processing Manual, chapter 30 at <http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf>

**Question:** *Regarding ABNs and NEMBs: Am I correct to understand that these are only to be issued to patients when I want to continue treatment, but have reason to believe that Medicare may not cover? If patient is being discharged as soon as I believe they no longer meet qualifications, do I need to give them any written form?*

**Answer:** The ABN and NEMB are issued to patients who want to continue treatment and are willing to pay for the services. If you are continuing to treat the patient for services that you believe are no longer reasonable and necessary, then you should give the patient and ABN in order to collect payment from the beneficiary. If you decide that you are going to discharge the patient and stop treatment, then no form would be necessary.

**Question:** *May we bill a Medicare patient if we do not have a signed NEMB ?*

**Answer:** If the service is not covered under the Medicare statutes (e.g. exceeding therapy cap, prevention and wellness), you may bill the patient without getting a signed NEMB; although CMS encourages you to obtain an NEMB. An NEMB is voluntary. If the service is not covered because it is not considered reasonable and necessary, then you would need to obtain an ABN in order to collect out of pocket payment from the beneficiary.

**Question:** *My patient has agreed to pay patient agrees and sign ABN and understands that therapy is no longer skilled - but, wants to continue as private pay. Do we submit each bill and each code from that point forward with the modifier? or, once we get the denial from Medicare*

can we just bill private? and, if by chance Medicare does not deny and the POC remains "as is" do we need to resubmit an ABN i.e 1 month later?

**Answer:** If the therapy services are no longer skilled, you would provide the patient with an ABN explaining that you believe Medicare will not cover these services because they are maintenance care (or specify whatever the reason is that they are not skilled). You would submit a bill with the GA modifier after the CPT codes describing the services you provided, indicating that an ABN is on file. In this instance you would only need to provide the ABN and submit the bill one time. Once you get a denial from Medicare, you could collect out of pocket or bill a third party payor. If you believe that the services should not be covered by Medicare, it would not be advisable to collect payment from Medicare.

**Question:** *I need clarification on which form to use when the patient has received a supply/DME and the clinic is not a supplier. In our situation the patient is not aware that the clinic is not a supplier. The slides (slide 69) indicate that the NEMB would be the appropriate form to use, but not necessary. To me, it would seem that the ABN would be the correct form to use. The patient could then make the decision to either pay for the service or go to a provider who is also a DME supplier.*

**Answer:** You are correct. If you do not have an NSC supplier number, then you would need to provide the patient with an ABN in order to collect payment for the items from the patient.

**Question:** *One of our patients brought in her denial notice. The second paragraph says "It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service." What if the person signed an ABN? Aren't you allowed to bill them then?*

**Answer:** If the provider had the patient sign an ABN and submitted the claim using the GA modifier, indicating that an ABN is on file, then the patient should not receive the message you described from Medicare stating "It appears that you did not know that we do not pay for this service, so you are not liable." Instead the patient should receive the following message from the contractor:

**Paragraph(s):**

We have reviewed your claim for (description of the services). When we reviewed your claim, we considered two things. First, we considered whether the service you received was necessary. Medicare will only pay for necessary services. We found that the prior decision was correct. The service was not necessary.

Second, we considered whether you knew, or were told, that Medicare would not pay. Medicare would not hold you liable if you did not know and your (doctor/supplier) did not tell you in advance, in writing, that Medicare would not pay. In that case, we would pay you any amount you pay or paid your (doctor/supplier) for the service. Our review shows that (choose one of the following to complete the sentence: **(the (doctor/ supplier) told you in writing, before giving the service, that Medicare would not pay); (this service had been denied on other claims for you); OR (we told you in a letter dated (DATE) that Medicare would not pay for this service))**). Since we believe you knew Medicare would not pay for this service, Medicare cannot pay. You are liable for the charges.

**If you do not agree** with our decision and \$100 or more is involved, **ask for a hearing**. The person holding the hearing will decide whether the service was necessary. That person will also decide whether you knew, or were told, Medicare would not pay. You must ask for a hearing within 6 months of the date of this notice. At the hearing, you may present any new evidence which would affect our decision. If you need help, your social security office will help you request a hearing.

cc: Physician/Supplier

**Question:** When patients have the appropriate diagnosis for their PT services, we use "KX" modifier when the patient has hit or exceeded their Medicare cap. When using this modifier, is it still necessary to use a NEMB form (or ABN form)-which ever is appropriate?

**Answer:** If a patient has exceeded the therapy cap and the patient is willing to pay out of pocket, then it is suggested that you give the patient an NEMB (however, giving an NEMB is voluntary). If the patient qualifies for an exception, then Medicare would pay and there would be no need to collect out of pocket from the patient. Therefore, the answer would depend on how certain you are that Medicare will pay for the service.

**Question:** It was suggested in the call that all Medicare out patients be given the NEMB form. What purpose does this serve especially because the NEMB is not a legal document. Why not have the patients sign the ABN when the need arises? I guess I am confused when to use the ABN and when to use the NEMB form.

**Answer:** There are certain situations in which the ABN form is given and certain situations in which the NEMB form is given to the patient. Neither of these forms should be given to all patients. They should only be given in circumstances when you believe that the service will not be covered and the patient is willing to continue receiving services and pay out of pocket for the services.

The purpose of the ABN form is to notify your patient that you are doubtful Medicare will pay for certain services because they do not meet Medicare's medical necessity requirements. When you give the ABN to your patients, explain that Medicare most likely will not pay for the services they are about to receive and why you think the service will be beneficial for their treatment. Your patient's signature on the ABN indicates that they agree to be financially liable for the service should Medicare, in fact, not reimburse you. Examples of such services would include those that your Medicare contractor has placed utilization guidelines on and therefore will not reimburse above and beyond a certain number (check your contractor's Local Coverage Determination, or LCD, to find out if this applies to you). Another service that would require an ABN is iontophoresis. Iontophoresis is a covered service by some Medicare contractors, yet not by others.

If you believe the care you are giving a patient at a particular visit may be construed by Medicare as maintenance care rather than restorative care, you may administer the ABN to insure that you will be paid for those services. Maintenance therapy does not meet Medicare's medical necessity requirements and all future maintenance visits for the same episode of care would become the patient's financial responsibility.

Similar to the ABN, the NEMB is a notice that you provide to your patients stating that they will be financially liable for the services they are about to receive. However, the NEMB is given when a service is *statutorily non-covered*. An example of when it would be necessary to administer the NEMB that is very much in the spotlight for 2006, is for physical therapy services that have exceeded the \$1740 shared Therapy Cap for physical therapy and speech-language pathology services. Should your patients choose to receive the remainder of their physical therapy from you above and beyond the Therapy Cap amount, this care becomes statutorily non-covered, and therefore their responsibility. The NEMB notifies them that they will be financially responsible for these services. Unlike the ABN, the NEMB does not have a signature block. It is advisable to add this to the form or have some other signed document in the patient's record indicating the patient's understanding of the notification of financial liability.

**Question:** When you say the ABN should be issued "each Time"...does that mean each treatment day AFTER therapist determines it is no longer reasonable and necessary?? I know it is ok for single ABN as long as it ids all items or services. .Why wouldn't we just wait the 48 hours for Medicare's decision and d/c the patient as planned?

**Answer:** If you determine that Medicare will not cover a service (e.g. the patient is no longer showing improvement), but the patient wants to continue to receive therapy and pay for it out of pocket, you would give the patient an ABN. In this instance you would give the ABN once after making this determination and that should be sufficient for the course of care.

With respect to the 48 hours, I believe you are referring to the Notice of Medicare Provider Non-Coverage. As of July 1, 2005, SNFs, HHAs, CORFs, and hospices must provide a Notice of Medicare Provider Non-Coverage (Generic Notice) to Medicare beneficiaries no later than two days before the effective date of the end of the coverage. This Notice lets them know that their Medicare coverage will be ending and they will be discharged. This requirement applies to CORFs (Part B), Home Health (Part A and Part B), and SNF (Part A and Part B). If the beneficiary does not agree that coverage should end, the beneficiary may request an expedited review of the termination decision by the Quality Improvement Organization (QIO) in that State. The provider then must furnish the Detailed Explanation of Non-Coverage (Detailed Notice) to the beneficiary explaining why services are no longer covered. Generally, the QIO's review will be completed within 72 hours of the QIO's receipt of the beneficiary's request for a review. Information about this expedited process is available at <http://www.cms.hhs.gov/Transmittals/Downloads/R594CP.pdf>

## **BILLING / CPT / CODING**

**Question:** *Can we bill for a telephone conversation with MD regarding patient current status (i.e. having a potential medical episode that require patient go to ER) that occurs during patient treatment session (patient is resting comfortably/safely at the time).*

**Answer:** You cannot bill anything extra for the telephone conversation with the physician regarding the patient's status. The time you spend speaking to the physician is considered post-service time.

**Question:** *We had a question regarding the Initial evaluation - can we treat the patient on the same day with the 59 Modifier? Or do we have to evaluate only - and treat on the next visit?*

**Answer:** Yes. You can provide an initial evaluation and treat the patient on the same day. However, you should check to determine whether there is a CCI edit involving the initial evaluation and the intervention you are provided. If there is a CCI edit, you may bill for the evaluation and treatment by appending the -59 modifier to the appropriate code. The evaluation must be medically necessary and distinctly separate from the therapeutic procedure. This must be clearly indicated in the documentation.

The Correct Coding Policy manual, which contains a list of the CCI edits, is available through the Center for Medicare and Medicaid Services website at [http://www.cms.hhs.gov/NationalCorrectCodInitEd/01\\_overview.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage). Physical Therapists in Private Practice should refer to the Physicians NCCI Edits found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage> while all other outpatient therapy settings should refer to the Hospital Outpatient PPS NCCI Edits found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage>

**Question:** *When I first started submitting 1500 claim forms I was unsure of what to put in the modifier column. I talked to my local carrier & they told me GP 59. That is what I'm using & I'm getting reimbursed, but I still don't understand the rationale of WHY that modifier is the correct one. Is it typically the modifier of choice?*

**Answer:** The -59 modifier (Distinct Procedural Service) is used to emphasize that when services are delivered, each of the services is distinct from the others. The most common use of this

modifier is with the Medicare Correct Coding Initiative edits. The allegation behind these edits is that providers were billing for multiple services during the same time period. For example, if the provider billed for 15 minutes of therapeutic exercise and 15 minutes of gait training, the patient must have been treated for (at least) 30 minutes. Medicare was (or is) of the belief that some providers would bill for both services even though their total time with the patient was only 15 minutes. To satisfy Medicare and its CCI edits, the codes should be modified with 59 to state that the two services, therapeutic exercise and gait training, were distinct services with their own distinct timing.

For example, if therapeutic activities is performed from 8:00am to 8:15am and manual therapy is performed from 8:15am to 8:30am on the same date of service, then the physical therapist may bill for both services using the -59 modifier. However, when billing with the -59 modifier, the physical therapist MUST be sure that the documentation in the file supports the bill. Thus, it should be clearly indicated in the file that the treatments were furnished during different time intervals.

**Question:** *How can we bill for patient treatment sessions that involve minimal hands on/exercise - but a significant amount of time is spent educating/counseling patient about their status/disease process etc.?*

**Answer:** Unfortunately Medicare does not cover the "Education and Training for Patient Self Management" codes (individual or group - 98960-98962) but other payers might. If you can document that patient education pertained to something like joint protection techniques for patients with Rheumatoid Arthritis or ergonomic considerations for low back pain, then you need to roll those patient education minutes into codes that represent the outcome you want to achieve (e.g. 97535 self care home management or 97112 for posture or 97530 for lifting techniques)

**Question:** *If a patient requires measurement for a compression garment, but does not require manual lymph drainage, which is the appropriate way to handle a 1-time treatment? Do I charge for an evaluation and compression measurement? Or can a PT just charge for the compression measurement alone without the evaluation?*

**Answer:** First, you should check your practice act to determine whether an evaluation is required. If your state practice act requires an evaluation, then you should perform an evaluation. You should consider skin integrity (before someone goes into a compression garment, this is important), ROM, use of the other extremity to help don the garment, and cognition (can the patient follow directions etc.) Therefore, it would be important to do an evaluation and not just measurements for the garment. The measurements (especially as compared to the other side so they can measure progress after the garment is utilized) can be part of the 97001.

**Question:** *Can we bill for group therapy and other charges on the same day example can patient A be in group therapy for 30 mins then receive 30 mins of 97110 etc?*

**Answer:** CMS has implemented a correct coding initiative edit that would prevent payment for group therapy in the same session as 97110, 97112, 97113, 97116, and 97140 unless a -59 modifier is used.

The -59 modifier may be used to indicate that services were performed in separate time intervals. Therefore, if the patient is in group therapy from 9:00-9:30 and then received one on one therapeutic exercise from 9:30-10:00, then the physical therapist may bill for both services using the -59 modifier. However, when billing with the -59 modifier, the physical therapist MUST be sure that the documentation in the file supports the bill. Thus, it should be clearly indicated in the file that the treatments were furnished during different time intervals.

**Question:** *In regard to the RE-EVAL—I understand the information that was provided to us in the audio conference, but in an out-patient hospital setting that is JCAHO accredited, re-evals are required every 30 days (every 2 wks for inpatients). So we typically have completed a re-eval as part of the end-of-billing 700/701 form. I know that the re-evals are rarely reimbursed. Is it acceptable then to still function in this manner? Transmittal 52 lists something about other regulations may require a re-eval, just that Medicare does not recognize this for the same reason.*

**Answer:** In order for Medicare to pay for the re-evaluation, you would need to meet Medicare requirements with respect to the re-evaluation. In its manual, CMS states that a “RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline or change in the patient’s condition or functional status that was not anticipated in the plan of care for that interval. Although some regulations and state practice acts require re-evaluation at specific intervals, for Medicare payment, re-evaluations must meet Medicare coverage guidelines. The decision to provide a re-evaluation shall be made by a clinician. . . . “A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient’s condition, or failure to respond to the therapeutic interventions outlined in the plan of care.”

This language should fit within the JCAHO requirements. If you use the -59 modifier, you may be able to get a reevaluation reimbursed that has been denied, depending on the circumstances.

**Question:** *I had a question about the difference between a re-eval and a re-certification. In the conference I thought you said that a re-eval was only preformed if there was to be a change in DX or some other significant change from the evaluation. Could you clarify this for me?*

**Answer:** A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient’s condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

*A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.*

**Question:** *We have found our patients respond best if they are 2 -3 times on land and 2 different days in the pool. This is a total of 4-5 days per week. Can we bill for all 5 days and get reimbursed?*

**Answer:** The answer to this question would depend. In order to get paid, you would need to make sure you are complying with all the Medicare requirements regarding skilled care and your Local Coverage Determination (if there is a policy regarding aquatic therapy or frequency of treatment). Many contractors have LCDs in which they state that they anticipate typical treatment to be 2-3 times a week for 6 weeks and that treatment beyond that would need to be supported by documentation. Therefore, if you were to provide care 4-5 times a week, your documentation would need to justify why it is medically necessary to provide therapy for 5 days/week. You should also consider whether your patient will exceed the \$1740 cap in a short time frame.

**Question:** We provide narrow-band UVB. We have always used the CPT code 97028. We were recently recommended by the distributor of the purchased light (National Biological Corporation) to bill for the services under incident to physician services and use the CPT code 96910 for the following reasons: It is supervised (we set the equipment, check the patient before and after treatment, and adjust the treatment as directed by the physician. There must be a physician, DO or PA onsite while the phototherapy or photochemotherapy is received. The physician on site does not need to be a dermatologist - a Radiologist, Pathologist or ER PA would meet standards. If none of the above clinicians are on site, phototherapy light treatments can not be provided. Is this correct for us to use as a CPT code? What are your suggestions on the correct CPT code use and correct interpretation of CPT code 97028?

**Answer:** I am not certain whether UVB is considered "photochemotherapy". If you are using the medication with the UV light, you could probably bill 96910. Without the medication, you should use 97028. There is a big difference in RVUs. The definitive answer might have to come from the American Medical Association.

## **TREATMENT TIME**

**Question:** I am confused about the 2 times required on treatment encounter note. Which times do we include in the treatment encounter note?

**Answer:** According to Transmittal 52, in your treatment encounter notes, you must document total timed code treatment minutes and total treatment time. The amount of time for each specific intervention/modality provided to the patient is not required, as it is indicated in the billing, but the billing and the total timed code treatment minutes must be consistent. See CMS IOM, Pub. 100-04, chapter 5, section 20.3 for description of billing timed codes.

Transmittal 52 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf>  
Timed code treatment would include the total minutes spent providing services described by timed codes. For example, if you spent 14 minutes on therapeutic exercise and 15 minutes on neuromuscular reeducation, the total timed code treatment minutes would be 29 minutes. If you also spent 15 minutes providing unattended electrical stimulation, the total treatment time would be 44 minutes. Therefore, you would need to record the 29 minutes as total timed code treatment minutes and the 44 minutes as total treatment time. You do not need to include untimed and unbilled services that are not part of the total treatment minutes. CMS has included information in the transmittal linked below on how to count minutes. <http://www.cms.hhs.gov/transmittals/downloads/R1019CP.pdf>

**Question:** If a person is referred to your clinic for a specific diagnosis (shoulder strain) which is not identified as a functional issue at eval, but balance, gait issues identified that contributed to the fall which lead to the shoulder strain are, can we place the treatment diagnosis as gait instability and treat the identified issues per our POC as long as the physician has signed?

**Answer:** Yes. You should make sure that the physician will sign the certification.

## **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. For example, they may include optional elements, such as short term goals.

**Question:** *When billing Medicare on a HCFA 1500 on line 19, previously the Date Last Seen by MD and the MD upin # had to be included. Is this information still necessary? Is there anywhere on the HCFA 1500 to put the date of the plan of care?*

**Answer:** Beginning October 2, 2006, the requirement that the date last seen by a physician be entered on the 1500 claim form will no longer be in effect due to change in policy previously made in CR 3648 (Pub 100-02, Transmittal 36, dated June 24, 2005). Transmittal 980, which includes this information, is available at <http://www.cms.hhs.gov/transmittals/downloads/R980CP.pdf>

**Question:** *We have the physician sign our treatment plan and referrals (RX). Do we need to obtain the original signature or will a fax copy be acceptable to keep in the patient's chart?*

**Answer:** A faxed copy of the referral and plan of care with the physician's signature in the patient's chart is acceptable.

**Question:** *In the Medicare Manual, Documentation Requirements for Therapy Services, there is a recommendation regarding goals and identification of goals. We currently write a list of short term goals (STG) and a list of long term goals (LTG), but do not link the STG to the specific LTG. From reading the documentation requirements, it seems that STG need to be written for each LTG - is that correct? Any other comments would be appreciated as to a good format for this. Also, if the LTG is met but not all of the STG, should we not work on the other STG unless we can add another LTG? It seems to me that once the LTG is met, any unmet STG (for that LTG) may be due to my not making good STG.*

**Answer:** 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 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.

**Question:** *I would like clarification on functional goals. I treat some active seniors and frequently have long term goals related to athletic pursuits. If I understood correctly, returning to playing tennis or golf is not goal that would be covered as skilled therapy. Is this the case? Do the goals have to be only related to ADL? Is returning to housework or yard work appropriate? Can I continue treatment to achieve these goals and have the patient sign the ABN form and collect payment up front or after Medicare denies payment?*

**Answer:** The therapist should not establish a goal for the patient of returning the patient to tennis or golf. The therapist could state in the chart that "returning to tennis" is the patient's goal. The therapist should identify an impairment that would be covered under the Medicare program and an appropriate goal; otherwise the treatment would not be covered and could be cash based. The goals do not have to be only related to ADL. With respect to your question about returning to housework or yard work, that could be an appropriate goal. I would recommend you use language like, "self-care/home management" if billing CPT code 97535 or "community/work reintegration if billing CPT code 97537. If the goals are to play tennis or golf, you could continue treatment to achieve these goals, but you should have the patient sign an ABN and collect payment from the patient if Medicare denies payment.

## **DENIALS / MEDICAL NECESSITY**

**Question:** *If you're treating a patient and they are not responding and you decide to discontinue their care after for ex. 4 or 5 treatments, can Medicare then come back and say that these treatments were not medically necessary and deny payment? If so, we just have to eat these visits?*

**Answer:** Medicare can pay for a service and later review the medical record for the claims billed and determine that they were not medically necessary. If Medicare determines they were not medically necessary, they will ask you to refund the money. If during the 4 or 5 treatments, your documentation supports that the services during those 4 or 5 sessions met the Medicare criteria for skilled therapy services, then they should not deny payment.

**Question:** *I had a patient who had a break in care of two weeks during the course of treatment. Will services after the break in care be covered by Medicare?*

**Answer:** Therapists should use their clinical judgment in circumstances involving breaks in care, but a break in care is often an audit review flag. The therapist should make sure their documentation clearly supports why skilled PT was necessary after the break, and documentation should reflect any change in the patient's objective functional status. It should be clear if there was any deterioration in status as a result of the break. If there was no change (worsening) or the patient is actually better, then of course the therapist will have to defend why continued skilled care is necessary.

A reassessment (not necessarily a reevaluation) would need to be documented to reestablish a new baseline from which progress will need to be made.

## **LOCAL COVERAGE DETERMINATIONS and NATIONAL COVERAGE DETERMINATIONS**

**Question:** *I know we are very close to getting an NCD that will not cover Anodyne as infrared. I know my patients can't/won't pay for this service. Is it permissible to do it with no charge for anyone who needs it in our clinic (all insurers)? My concern with this approach, since it is not a bundled charge, is that the OIG could see this as providing an incentive to come to our facility (which I do not want to do). My other thought is that after doing it once or twice (and making the patient aware that they will be billed initially), it will not take 8 minutes to put it on and periodically monitor. In this case, there would be no charge. What do you think about this? If the NCD is issued as the draft, would I be correct that this would need to be billed as an unlisted modality (97039)?*

**Answer:** I strongly advise against providing Medicare beneficiaries free of charge. Providing services free of charge could be considered a violation of the antikickback laws as it would induce the patients to select your facility over another facility. With respect to other insurers (non-Medicare) I recommend you look at your state laws to determine whether there are any laws against provision of free services. If you provide the service for less than 8 minutes and do not charge, I think that the same concerns would apply. You are still providing a service for free.

The NCD regarding infrared devices is currently in draft form. CMS is proposing to issue the following determination "The use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is not covered for the treatment of diabetic and/or non-diabetic peripheral neuropathy, wounds and/or ulcers of skin and/or subcutaneous tissues in Medicare beneficiaries." After considering public comments on this proposal, they will release a final decision memorandum. Information about this is available on CMS's website at <http://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=176>

Until the decision is finalized, you should defer to your local contractor's policy regarding the coverage of Anodyne. If your contractor is willing to cover it and there is no NCD, you would bill Anodyne using CPT code 97026 (infrared).

**Question:**

*I have the LCD from our area contractor, National Heritage Ins. Co. There is a list of ICD-9 codes that "support medical necessity" for rehab. On this list there are NO codes for shoulder problems such as rotator cuff tendonitis, only frozen shoulder. There are NO codes for back problems such as spinal stenosis, just "Lumbago." Does this mean that these codes listed are the only codes that they will pay for? (I was told that through the grapevine). I guess that means I have to make my patients' diagnoses into little origami shapes that fit these codes, if so. They don't even have the automatic exception codes in this list, although maybe they assume that those are NCD issues and so they don't need to list them.*

**Answer:** We have heard quite a bit from physical therapists concerning the new NHIC local coverage determination (LCD). It is understandable that the requirements of this LCD are causing confusion.

Concerning the ICD-9s that support medical necessity, it is APTA's understanding that NHIC would like physical therapists to utilize codes based on the patient impairment, and not the medical diagnosis. This can get complicated when you have a patient who will exceed the Therapy Cap and the exception code is not listed in the LCD. We have been recommending that physical therapists add the exception code to the claim form, if there is room, but the condition that meets the exception should be primarily documented in the clinical record. APTA addressed this question in a "Frequently Asked Question" document on the Therapy Cap Exceptions Process available at:

<http://www.apta.org/AM/Template.cfm?Section=Medicare1&Template=/MembersOnly.cfm&NavMenuID=528&ContentID=28914&DirectListComboInd=D>.

You may also wish to follow-up with customer service at NHIC for further clarification on this issue.

**Question:**

*On June 12 of this year, NHIC who administers Medicare in California quietly changed the way they process claims. They changed guidelines for reasonable and customary, shortened treatment times by limiting the number of units that they will allow in one visit, and are refusing to pay for manual therapy in many situations... to name but a few. So...We understand from your presentation that each state can determine how Medicare benefits are administered and make individual decisions re. how they pay for out-pt PT. Is this true? Did we understand this correctly? Did something change this summer that allows NHIC to reduce the Medicare PT benefit in this way? Is there some new federal policy you can direct us to? ...or some other explanation for the change at this time? Are you aware of these changes and are they occurring across the country? Why have we not heard about this in the media? Many of the new policies require documentation to validate the necessity of treatment beyond their stated limits. Have you found that Medicare is asking for submission of the documentation with the initial billing? Or do we do it when the claim is denied? Have you found instances when they do not even pay when we can document necessity?*

**Answer:** We have heard quite a bit from physical therapists concerning the local coverage determination (LCD) recently issued by NHIC, the Medicare carrier in California. It is understandable that the requirements of this LCD are causing confusion.

Coverage of services in the Medicare program is largely determined on the local level. Medicare contractors have a lot of discretion to formulate payment policy. The contractors must take into account standards of practice when formulating these policies, but there can be a lot of variation. They must also take into account National Coverage Determinations (NCDs), and cannot create policies that conflict with them. NCDs, however, only comprise about 10% of Medicare payment

policy and this is why the individual contractors have so much discretion. NHIC is now requiring the use of diagnosis codes that relate to impairment and not necessarily the medical diagnosis of the patient, however, the medical diagnosis from the referring physician should be included in the patient's clinical documentation.

As a general rule, when an LCD states that utilization of services beyond a certain number of units requires additional documentation, this documentation should exist in the record so it is readily available if requested. If the LCD states that additional documentation is required to support the use of additional services, and this documentation is of high quality and available upon request, then the claim should be paid for.

## **THERAPY CAP EXCEPTIONS**

**Question:** *We have a patient that wants to continue receiving Physical Therapy services even though he will exceed the \$1740 cap soon. This patient does not qualify for the automatic exception but may qualify for a manual exception which is in the process of being submitted. Can we continue to see this patient if we have the correct ABN signed just in case it is denied?*

**Answer:** It is advisable to submit the request for a manual exception to the contractor before the beneficiary has exceeded the cap so that the beneficiary is not put at risk of paying out of pocket for services. If you are not certain whether the patient has exceeded the cap, you should give the patient an ABN. If you believe that the patient has exceeded the cap, you should give the patient an NEMB. However, the NEMB is not mandatory.

**Question:** *May we bill a Medicare patient if he has exceeded the cap and signed a NEMB form?*

**Answer:** Yes. However, your patients should be provided with accurate information regarding their financial responsibilities if therapy services exceed the financial limits. Although CMS does not require a specific format for patient notification, the NEMB (Notice of Exclusion of Benefits) is recommended. This form can be downloaded from the CMS website at:  
[http://www.cms.hhs.gov/BNI/11\\_FFSNEMBGeneral.asp#TopOfPage](http://www.cms.hhs.gov/BNI/11_FFSNEMBGeneral.asp#TopOfPage)

Within the NEMB, you should check box #1 and give the following reason for denial: "Medicare will not pay for physical therapy and speech language pathology services over \$1740 in 2006." While the NEMB does not include a patient signature block, it is advisable to add this to the form or have some other signed document in the patient's records indicating the patient has received the NEMB or a similar notification. Patients should also be informed that they can continue to receive covered services through a hospital outpatient therapy department, if possible.

**Question:** *If a patient has attended and exhausted P.T. under the cap, and then returns for a different condition are they entitled to a new cap (with or without the KX auto exception) and/or a new automatic exception if the diagnosis is on the list?*

**Answer:** If the patient returns for a different condition and will exceed the cap, the patient would qualify for an automatic exception.

**Question:** *I have written documentation from APTA that says the extension entails 14 additional visits. However, when I spoke to Medicare regarding an extension, I was told there is not an exact number of visits included in an extension. She was somewhat vague, but what I got was that as long as we can provide Medical Necessity documentation we can continue treatment. Do you have any knowledge of this?*

**Answer:** The answer to your question depends on whether the patient qualifies for an automatic exception or a manual exception. There is no established limit on the number of additional visits for automatic exceptions. However, Medicare will only pay for services that are medically necessary. Medical necessity must be supported by documentation. If you are seeking a manual exception, the provider's request should specify the number of additional treatment days after the cap has been reached, but may not exceed 15 future treatment days for each discipline (PT, OT,

and SLP). The contractor may approve fewer days than the number requested by the provider. If the provider determines that the episode of treatment extends beyond the amount that has been approved, the provider can submit a request for further cap exception.

**Question:** *Is there a way to find out how much physical therapy a patient has been "allowed" by Medicare in regard to claims and the therapy cap?*

**Answer:** Your contractor should tell you the dollar amount remaining. In the alternative, you could get this information if you have access to the ELGA (for claims submitted to intermediaries) and ELGB screens (for claims submitted to carriers). ELGA screens are available, but only a few contractors have made ELGB screens available.

**Question:** *If we see a patient and do not use the KX modifier and exhaust the cap, and they then have a different condition, can they return under an exception and KX modifier as an auto exception or do they then become a potential manual exception.*

**Answer:** CMS includes a list of additional complexities that would allow for an automatic exception to the therapy cap. One of these complexities is multiple episodes for different conditions during the calendar year. The clinician's documentation must justify the use of the modifier.

**Question:** *Is the Common working file only for agencies that bill a Fiscal Intermediary? If not, from the vague information that I have on the CWF, I think that it would be a helpful tool in tracking where the beneficiary is in meeting their therapy cap.*

**Answer:** The common working file is used by both carriers and intermediaries. The CWF is used to track how many dollars the beneficiary has used for therapy services.

## **PTAs & Aides**

**Question:** *In private practice where the PT must be present for PTA to treat patients, is it acceptable if "a" PT is present, but not "the PT that did the initial examination"?*

**Answer:** It is acceptable to have a PT providing the supervision who did not provide the initial examination.

**Question:** *Does CMS recognize minutes of treatment for services provided by aides in the Acute Rehab setting?*

**Answer:** At this point, CMS does not have a policy regarding the use of aides in the acute rehab setting. In these settings, CMS defers to state law and medical staff policies. However, the physical therapy services provided in the rehab hospital should be skilled.

**Question:** *In the scenario of a PT and a PTA providing different portions of treatment to a patient on the same day (such as, the PT performs a specific mobilization technique & the PTA carries out the therapeutic exercise portion), is it necessary to indicate which licensed person performed which intervention, which in turn indicates the time spent by each person. Is it acceptable for the PT to indicate in the progress note that the PTA completed the treatment, etc? I am asking this to help clarify if there is an audit & the TIME IN/TIME OUT for the same PT may go into another patient's TIME IN/TIME OUT. By the same token, the un-timed code for one patient may be during a timed hands-on time with another patient.*

**Answer:** CMS includes the following language in Transmittal 52 (<http://www.cms.hhs.gov/transmittals/downloads/R52BP.pdf>) related to the daily encounter notes with respect to identification of PTs and PTAs who contributed to the treatment.

1 “Signature and professional identification of the qualified professional who furnished or supervised and list of each person who contributed to treatment during that encounter (i.e., the signature of Kathleen Smith, LPT, supervisor, with notation of the assistance of Judy Jones, PTA, when permitted by state and local law).”

Based on this information, it appears that it would be appropriate for the physical therapist to include a notation that the PTA provided certain services.

**Question:** The practice act in my state allows COTA's to do evals, but they must be supervised by an OT. Do the Medicare regs. only pay for evals done by an OT?

**Answer:** Medicare will only pay for evaluations done by the OT, not the COTA.

## **WOUND CARE**

**Question:** It is my understanding that according to CMS that when a wound displays no evidence of nonviable debris that skilled Physical Therapy is no longer reimbursable? Regardless of depth, size or undermining? Is this the case and can you provide a reliable source as a documented reference?

**Answer:** Debridement requires removal of non-viable tissue. But, an open wound is still an open wound and may require other treatment (e.g. negative pressure wound therapy). We are not aware of a Local Coverage Determination (LCD) that states the wound must only have necrotic tissue to be eligible for wound care. However, you should search to determine whether there is an LCD issued by your contractor that addresses wound care. Information on LCDs is available at <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS014961>

## **MISCELLANEOUS**

**Question:** Does the diagnosis that appears on the UB92 have to be the diagnosis that the physician writes on the signed original order for physical therapy?

**Answer:** There are multiple spaced on the UB 92 for diagnoses. You should include the medical diagnosis of the physician and also your physical therapy diagnosis on the claim form.

**Question:** Can a SNF resident who is not on Med A be sent out to our center for outpatient therapy and billed under Med B by us when it is a specialized treatment intervention - i.e. lymphedema management - that the SNF does not have the training to provide?

**Answer:** If the patient is a SNF patient, then the SNF must do all the billing due to consolidated billing provisions. It may be possible for the SNF to contract with therapists who have specialized training in lymphedema management to provide services to the SNF patients. If these circumstances, the SNF would pay a fee to the therapists providing the lymphedema management and the SNF would bill Medicare for the services.

**Question:** Can a hospital based OP provider bill for services rendered in the home setting using home as the place of service code for an entire plan of care? i.e. a senior apartment complex where the patient is not considered home bound?

**Answer:** Yes. The hospital may send therapists to the patient's home to render services. The hospital should check to make sure that the patient is not receiving services from a home health agency under a home health plan of care.

**Question:** Under an independent physical therapist, can a Physical therapist waiting for his or her license work?

**Answer:** To bill under the Medicare program, licensure is required. So, in most instances the answer would be "no." However, some states may recognize some form of temporary licensure. You would need to check state laws.