

FREQUENTLY ASKED QUESTION (FAQS)  
PTS AND MEDICARE AUDITS: REDUCING YOUR RISKS

Fraud and Abuse

**Q: Where can I get information regarding Stark II self-referral laws?**

A: Resources are available on APTA and CMS' websites. Please visit the following links.

Text of the Legislation:

[http://www.ssa.gov/OP\\_Home/ssact/title18/1877.htm](http://www.ssa.gov/OP_Home/ssact/title18/1877.htm)

APTA Prepared Summary of Stark II Final Regulations:

[http://www.apta.org/AM/Template.cfm?Section=Fraud\\_and\\_Abuse&CONTENTID=18342&TEMPLATE=/CM/ContentDisplay.cfm](http://www.apta.org/AM/Template.cfm?Section=Fraud_and_Abuse&CONTENTID=18342&TEMPLATE=/CM/ContentDisplay.cfm)

CMS Information:

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

**Q: Per Medicare guidelines, can an administrator for a Physical Therapist be shared with another entity (i.e.) Internal Medicine Specialist who will be sharing space together to cut cost.**

A: When permitted by applicable regulations, two practices may share space together and administrative staff to cut costs. However, if a physical therapist is involved in sharing space with a physician that physical therapist must be certain that he/she complies with the federal antikickback statute and Stark II self-referral laws. The anti-kickback statute states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of healthcare program business can be held accountable for a felony. The Stark II Law, prohibits a physician from making a referral to an entity with which the physician or any member of the physician's immediate family has a financial relationship, if the referral is for the furnishing of a designated health services (DHS) which includes physical therapy services, and prohibits the entity from submitting claims to Medicare or Medicaid for the service, unless an exception applies.

The HHS Office of Inspector General (OIG) has issued an alert that includes a discussion of sharing common office space in physician's offices, such as waiting rooms. In this Alert they state that if suppliers use common areas for their patients, it may be appropriate to pay a prorated portion of the charge for the space. The charge for the common space must be apportioned among all physicians and subtenants that use the interior office common space based on the amount of non-common space they occupy and the duration of such occupation. "Payment for the use of office common space should not exceed the supplier's pro rata share of the charge for such space based upon the ratio of the space used exclusively by the supplier to the total amount of space (other than common space) occupied by all persons using such common space."

The Fraud Alert is available on OIG's website at the link below.

<http://oig.hhs.gov/fraud/docs/alertsandbulletins/office%20space.htm>

**Q: We rent outpatient PT space from an assisted living/senior living center/fitness center in town. Our rent is a percentage of our collections from the month. Our clinic sees patients of all ages and**

they do not all come from that particular facility. They do not directly refer patients to us. There are no physicians on staff, but there is nursing that suggests to some of the residents that PT may help them and help them get an order for us. Are there any problems with this set up for rent?

A: Rental arrangements that are based on a percentage of collections from the month could be considered suspect under anti-kickback laws. It would be advisable to set the amount of rent in advance, not base the rent on volume or value of referrals, and ensure that the rental amount is set at fair market value, and that the space rented is commercially reasonable.

The OIG has a Fraud Alert on its website that addresses rental arrangements. Although it applies to arrangements involving a physician referral source, many of the issues addressed should be considered when involved in any rental arrangements.

<http://oig.hhs.gov/fraud/docs/alertsandbulletins/office%20space.htm>

**Q: Is there any problem with advertising physical therapy services for Medicare patients?**

A: You can market physical therapy services, but there are guidelines for appropriate marketing practices. Please reference the following APTA FAQ for further details.

[http://www.apta.org/AM/Template.cfm?Section=Fraud\\_and\\_Abuse&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=28509](http://www.apta.org/AM/Template.cfm?Section=Fraud_and_Abuse&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=28509)

### Audits

**Q: My question concerns PT in private practice setting. Do Medicare audits always take the form of off-site documentation review? Can it be also done as on-site auditing? If the answer is yes - what are my rights as a provider? Do I have to allow the auditors immediate access to my clinical and financial documentation once they step in to my office? Can I request some time to re-check and prepare my documentation before submitting it to the auditors?**

A: An audit can be off-site or on-site. Some auditors may visit your office staff, colleagues, and even patients. It would be advisable to contact your attorney immediately if you are being audited. Your attorney should hire a coding expert to review the charts, preferably before you submit them to the auditor. Your attorney should have the review done under the attorney work product privilege so that the results will be confidential. Before submitting claims, you should review all the charts and be certain to include everything that could support the claim billed. For example, the auditor may ask for notes from a particular date of service. It might be helpful to include other notes and the plan of care, etc in addition to support coverage for the services.

You should not change your documentation after the fact. However, if you are missing documentation supporting your claims, you could add more language or explanation through an addendum that is dated as of the date of the addition. If you're missing any documentation supporting your claims, add a clearly labeled and dated addendum, or include an explanation in your cover letter.

**Q: Can repetitive overpayment letters from Medicare trigger a Medicare audit? If so, how can I protect myself?**

A: If Medicare notices a pattern that seems to indicate repeated overpayments, there is an increased probability that an audit could occur. The best way to protect yourself is to be aware of the Medicare rules regarding documentation, coding, and billing for services and ensure that you have policies in place in your practice that will minimize billing and coding errors.

**Q: Due to a recent RAC audit it was determined that the code 97150 was used improperly. The definition for 97150 is Therapeutic procedure(s) group (two or more individuals) It was used in an outpatient clinic with the P.T. present. Why weren't we entitled to payment? The RAC response was "Service at the same time by more than one doctor are not covered" What are we not understanding ? Explain when to use 97150.**

A: You should provide the RAC with Medicare's definition of group therapy, which is included in its Medicare Benefit Policy Manual, Chapter 15, section 230. According to CMS "contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required." The link to the Manual containing this language is below.

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

CMS includes scenarios demonstrating billing for group therapy on its webpage at [http://www.cms.hhs.gov/TherapyServices/02\\_billing\\_scenarios.asp#TopOfPage](http://www.cms.hhs.gov/TherapyServices/02_billing_scenarios.asp#TopOfPage)

**Q: I was told that if you recognize you are doing something wrong in your clinic, you should document it and show how you will be changing it from that date forward. This should be documented in your compliance manual. I heard if you were audited that they would look at this and possibly be less harsh on you if they see this. Is this opening yourself up to further scrutiny? I'm thinking of this because of the mention of going through legal counsel to keep information privileged. What is your advice?**

A: It is good to identify problems and immediately change them moving forward. You should not try to alter documentation that has been previously written. If you take corrective action, there is a likelihood that the penalties will be less harsh if you are audited.

**Q: If a PT is contracting for a Medicare Part B agency, what is the level of responsibility for the agency and the contracting PT respectively if audited?**

A: As mentioned in the presentation, if there is fraud or abuse of the Medicare program both the physical therapist and the practice owner or agency bears responsibility. The level of responsibility and punishment varies based on the type of law(s) violated. In one example provided during the conference call, a home health agency hired a person as a PT who falsified her employment information and credentials. This individual did serve time in prison. Despite the fact that the home health agency cooperated in the investigation, there were extreme penalties for the home health agency as well.

## Local Coverage Determinations

**Q: Where can we find the local coverage determination (LCD) for Kentucky? I have gone to CMS' website and cannot locate it.**

A: The local coverage determinations for the various contractors can be found on the website of your carrier or fiscal intermediary. LCDs can be referred to as a medical policy or an LCD. In addition, you can find the physical therapy or physical medicine and rehabilitation LCD through APTA's website at the following link.

[http://www.cms.hhs.gov/mcd/index\\_lmrp\\_bystate.asp?from2=index\\_lmrp\\_bystate.asp&](http://www.cms.hhs.gov/mcd/index_lmrp_bystate.asp?from2=index_lmrp_bystate.asp&)

**Q: I was recently told the patient's must see a physician every thirty days. In the question and answer period, it was stated this rule was eliminated in 2005. Is it possible that the local carrier could require this?**

A: The physician visit requirement was eliminated effective June 2005. **A local carrier cannot require a physician visit unless the physician specified that he/she needs to see the patient in a certain time frame.**

## Personnel Use: Aides, Students, and Physical Therapist Assistants

**Q: Can you clarify how a tech/aide can be utilized in an outpatient setting?**

A: According to Medicare:

"Services provided by aides, even if under the supervision of a therapist, are not therapy services in the outpatient setting and are not covered by Medicare. Although an aide may help the therapist by providing unskilled services, those services that are unskilled are not covered by Medicare and shall be denied as not reasonable and necessary if they are billed as therapy services."

<http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf> (pg. 29)

In a letter of clarification APTA received from the Centers for Medicare and Medicaid Services, it was stated:

"As the title 'aide' conveys, the therapy aide is there to facilitate the receipt of needed therapy services. For instance, when a beneficiary needs to be lifted into a whirlpool, or needs the support of two people in order to ambulate safely; the aide may assist the therapist who is the provider of the therapy service."

[http://www.apta.org/AM/Template.cfm?Section=Assistants\\_Aids\\_Students&CONTENTID=18838&TEMPLATE=/CM/ContentDisplay.cfm](http://www.apta.org/AM/Template.cfm?Section=Assistants_Aids_Students&CONTENTID=18838&TEMPLATE=/CM/ContentDisplay.cfm)

In addition, APTA has an association policy regarding aides.

PROVISION OF PHYSICAL THERAPY INTERVENTIONS AND RELATED TASKS HOD P06-00-17-28  
(Program 32) [Amended 06-99-10-12] [Position on Physical Therapy Intervention] [Position]

Physical therapists are the only professionals who provide physical therapy interventions. Physical therapist assistants are the only individuals who provide selected physical therapy interventions under the direction and at least general supervision of the physical therapist.

Physical therapy aides are any support personnel who perform designated tasks related to the operation of the physical therapy service. Tasks are those activities that do not require the clinical decision making of the physical therapist or the clinical problem solving of the physical therapist assistant. Tasks related to patient/client management must be assigned to the physical therapy aide by the physical therapist, or where allowable by law, the physical therapist assistant, and may only be performed by the aide under direct personal supervision of the physical therapist, or where allowable by law, the physical therapist assistant. Direct personal supervision requires that the physical therapist, or where allowable by law, the physical therapist assistant, be physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed. The physical therapist or physical therapist assistant must have direct contact with the patient/client during each session. Telecommunications does not meet the requirement of direct personal supervision.

<http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=25472>

**Q: If a tech is following the plan of care, as written and supervised by the PT, can they direct a patient in exercises?**

A: Please see above. An aide's services are not billable under Medicare in the outpatient setting.

**Q: Are physical therapy techs allowed to treat a Medicare patient with e-stim provided a licensed physical therapist is present?**

A: The answer to your question would depend on your practice setting and state practice act. In a SNF Part A setting, Medicare allows an aide's services to count as minutes on the MDS if state laws allows it and the aide is in the "line of sight" of the therapist. In an outpatient setting, if an aide provided e-stim, it would not be billable regardless of whether the licensed physical therapist is present.

**Q: If the tech is instructing a patient in exercises while being supervised by a PT, can Medicare be billed for a group exercise?**

A: In outpatient therapy settings, an aide/tech may not be responsible for group therapy. A physical therapist or physical therapist assistant must provide the group therapy session in order for it to be payable by Medicare.

**Q: If a PTA is treating a patient and documents incorrectly or makes an error who is ultimately responsible- the supervising PT or the PTA?**

A: The answer to your question depends on the circumstances. Certainly, a physical therapists could be held responsible for his/her actions that were in error. Also, the physical therapist is ultimately responsible for supervising the physical therapist assistant so he/she could be held responsible for the error also.

According to Medicare, "The services of PTAs used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising physical therapist. PTAs may not provide evaluation services, make clinical judgments or decisions or take responsibility for the service. They act at the direction and under the supervision of the treating physical therapist and in accordance with state laws."

<http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf> (pg. 29)

**Q: Can a PTA do a status report on a patient and have the PT review the report and co-sign?**

A: A PTA can write a daily note or write PTA progress notes that would supplement the notes of the physical therapist. A PTA cannot provide evaluation services or make clinical judgments or decisions. A physical therapist must write the evaluation/reevaluation and the progress report.

Specifically, the Medicare manuals state the following with respect to PT and PTA signatures on the daily treatment note:

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

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> (pg. 155)

**Q: Can a PTA write a progress note?**

A: No. PTA's may write PTA progress notes that supplement the PT progress note. These notes would not be considered complete progress reports. Medicare guidelines stipulate:

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

Progress Reports written by assistants supplement the reports of clinicians and shall include:

- Date of the beginning *and end* of the *reporting period* that this report refers to;
- Date that the report was written (*not required to be within the reporting period*);

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

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

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

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

<http://www.cms.hhs.gov/transmittals/downloads/R60BP.pdf> (pg. 33)

Q: Is it a requirement that a PT remain on site to supervise a PTA in a private practice setting?

A: In a private practice setting, physical therapy services must be provided by or under the direct supervision of the physical therapist in private practice. CMS has defined direct supervision to mean that the supervising private practice therapist must be present in the office suite at the time the service is performed.

[http://www.apta.org/AM/Template.cfm?Section=Assistants\\_Aids\\_Students&Template=/MembersOnly.cfm&ContentID=25894](http://www.apta.org/AM/Template.cfm?Section=Assistants_Aids_Students&Template=/MembersOnly.cfm&ContentID=25894)

Q: There has been some confusion about "incident to" billing for services provided in a physician's office. Specifically, if a PTA is working under direct supervision of a PT, both of whom are employed by a group of board certified orthopedic surgeons, can services provided by the PTA - on

**the plan of care established by the PT and certified by the referring physician - be billed by the physician's office under the "incident to" provision of the CMS?**

A: No. A physician may not bill "incident to" for services provided by a physical therapist assistant. A physical therapists working in a physician's office may obtain his/her Medicare provider number as a physical therapist in private practice and reassignment payment to the physician practice. The services of a PTA under the supervision of a PT are billable when the PT obtains his/her own PTPP provider number, bills under that number, and reassigns payment to the physician practice.

**Q: Could you please clarify what it means by "students may participate in care with proper PT involvement?" As a student, I thought any time I spent working with the patients in an outpatient setting was not billable even if the therapist was standing right there watching me.**

A. Medicare has set forth the policy described below regarding involvement in the provision of outpatient therapy services by students.

## ***B. Therapy Students***

### ***1. General***

*Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present "in the room".*

#### ***EXAMPLES:***

*Therapists may bill and be paid for the provision of services in the following scenarios:*

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.*
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.*
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services).*

### ***2. Therapy Assistants as Clinical Instructors***

*Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.*

### ***3. Services Provided Under Part A and Part B***

*The payment methodologies for Part A and B therapy services rendered by a student are different. Under the MPFS (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or Resource Utilization Group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determines the RUG category. Payment levels for each category are based upon the costs of caring*

*for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.*

A student supervision chart and other information regarding the student provision of physical therapy services can be found at the following link on APTA's website.

[http://www.apta.org/AM/Template.cfm?Section=Assistants\\_Aids\\_Students&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=167&ContentID=18284](http://www.apta.org/AM/Template.cfm?Section=Assistants_Aids_Students&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=167&ContentID=18284)

**Q: Please let me know where I can locate a website where I can get job descriptions on Physical Therapist, Physical Therapist Assistant, and Physical Therapy Technician.**

A: APTA has definitions for these terms as adopted by the association's governing body, the House of Delegates. These definitions have been provided below. You should also consult the qualification guidelines of your various payers, such as Medicare, to ensure that they do not have additional qualifications that could impact reimbursement.

**Physical therapists (PTs)** are health care professionals who diagnose and treat individuals of all ages, from newborns to the very oldest, who have medical problems or other health-related conditions that limit their abilities to move and perform functional activities in their daily lives.

[http://www.apta.org/AM/Template.cfm?Section=Physical\\_Therapy&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=217&ContentID=34361](http://www.apta.org/AM/Template.cfm?Section=Physical_Therapy&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=217&ContentID=34361)

**Physical Therapist Assistant:** The physical therapist assistant is a technically educated health care provider who assists the physical therapist in the provision of physical therapy. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE).

<http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=25672>

**Physical Therapy Aide:** Physical therapy aides are any support personnel who perform designated tasks related to the operation of the physical therapy service. Tasks are those activities that do not require the clinical decision making of the physical therapist or the clinical problem solving of the physical therapist assistant.

<http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=25472>

### Plan of Care

**Q: Does a physician referral once a month suffice or do I need to have a signed Plan of Care?**

A: Medicare requires that the physician review and sign the plan of care every. If the physician's referral contains all of the required contents of the plan of care (i.e. duration, frequency, diagnosis, goals), then that referral could be considered the plan of care.

**Q: A plan of care (POC) is supposed to be signed by the physician every month. Is there a 10 visit rule where a POC must be signed? Because if you are seeing a patient 3X/wk for 4 weeks then by the time a month would come up they would be on their 12<sup>th</sup> visit.**

A: The plan of care must be recertified every 30 days. A physical therapist must be involved in the treatment visit of a patient every ten visits or 30 days, whichever is less.

**Q: If the initial plan of care indicates an initial frequency of 3xwk8, is another plan of care/re-evaluation needed in 30 or 60 days?**

A: Regardless of what may be included in the physician referral, a plan of care needs to be certified and recertified every 30 days.

**Q: If the physician referral states evaluate and treat, are we able to bill for the evaluation and the treatments or do we need to wait until our evaluation with the plan of care comes back signed by the physician before we can bill for services rendered?**

A: A physical therapist should establish the plan of care before beginning treatment and send it to the physician for review and certification as soon as possible. The physical therapist has 30 days from the date of the patient's first encounter with the physical therapist, to obtain the physician's signature on the plan of care.

**Q: Can a referral from a physician become outdated? I suppose as long as they sign the POC it does not matter. Is this correct?**

A: Medicare does not have policies regarding at what point a referral for therapy services becomes outdated. However, you should check with your state law to determine if the state has any laws or regulations relating to the timing of the referral. In your professional judgment, you need to determine whether the patient should return to the physician and whether it is clinically appropriate for you to treat the patient.

**Q: The CMS regulation stipulating "every 30 days or 1 month whichever is longer" for the POC certification period is confusing. Would you please provide a few calendar examples of 30 days/1 month clarification? For example: a POC was established on May 16, 2007. Is it good until June 16, 2007 (this is actually 32 days), good until June 15, 2007 (31 days), or June 14, 2007 (30 days?) Or does the "1month" have to begin on the first day of the month, e.g. May 1 to May 31?**

A: The timing for the certification begins with the first therapy encounter. It is not associated with the first day of the month.

### Documentation

**Q: Are you supposed to document time somewhere on the note? I am aware and follow the time guidelines but do not put it on the note.**

A: Medicare requires that you put the total treatment time and the amount of time spent on timed codes in the treatment note. For example, if a patient was treated for 45 minutes total and of that time 23 minutes were spent on one or more timed codes, your treatment note should reflect the 45 minutes of total treatment time and the 23 minutes spent on timed codes.

According to CMS, documentation of each Treatment shall include the following required elements:

• Total timed code treatment minutes and total treatment time in minutes. Total treatment time includes *the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). For Medicare purposes, it is not required that unbilled services that are not part of the total treatment minutes be recorded, although they may be included voluntarily to provide an accurate description of the treatment, show consistency with the plan, or comply with state or local policies. The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but contractors shall not require it, as it is indicated in the billing. The billing and the total timed code treatment minutes must be consistent. See CMS IOM, Pub. 100-04, chapter 5, section 20.2 for description of billing timed codes; <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> (pg. 155)*

**Q: How long has the time documentation requirement for Medicare beneficiaries been in effect?**

A: The time requirement reference and described above became effective in 2006. Previously, Medicare did require documentation of time, but did not include the exact language above.

### **ABN vs. NEMB**

**Q: Can you provide examples of when to use an ABN vs. NEMB for outpatient private practice.**

A: An ABN should be signed by a patient if you doubt that Medicare will pay for certain services because you have made a clinical judgment that the services would not meet Medicare's definition of medical necessity. A NEMB should be given to a patient when a service is statutorily non-covered. An example of use of the ABN would be if your local coverage determination does not allow coverage for iontophoresis. An example of when it is appropriate to use an NEMB would when if the patient has exceeded the therapy cap or the services are prevention and wellness.

**Q: We have a Medicare patient who no longer meets the reasonable & necessary standards. This patient wants to continue to come in and is willing to pay out of pocket. We put the patient on a supervised maintenance program and she has signed an ABN. Am I required to bill Medicare for this service? If I so, do I run the risk of Medicare paying for this service, and then being guilty of false billing?**

A: If you place the GA modifier on the claim indicating that you know the service is not covered and that there is an ABN on file, Medicare should not pay the claim. If you are paid, you should return the funds.

**Q: What is the purpose of the GA modifier and billing for something we know they are not going to pay for, as long as the patient signs the ABN?**

A: The Medicare instructions on the ABN advise the provider to submit the bill with a GA modifier indicating an ABN is on file. You may need to get the denial if the patient's secondary insurance requires it.

**Q: Is an ABN required every time we perform the service, or can they sign one to cover all the treatment dates in that treatment period?**

A: You only need one ABN signed for a particular service. For example, if the service is iontophoresis, it would only be necessary to have one signed ABN for iontophoresis. Subsequently, if you determine that another service is not covered (e.g. infrared), you would need a separate ABN regarding infrared.

**Q: We have independent gym program with monthly membership dues. When patients are discharged from PT they have an option to join the gym program. Do we need to have our Medicare patients to sign ABN form? Do we need to bill Medicare for that?**

A: Medicare does not cover gym memberships. You would not need to have the patient sign an ABN or bill Medicare for joining the gym. These services would be considered prevention and wellness.

### Therapy Cap

**Q: What is the current therapy cap amount under Medicare?**

A: The cap is \$1780 for calendar year 2007 for physical therapy and speech therapy combined. There is a separate \$1780 cap for occupational therapy.

**Q: If a patient meets the criteria for the Medicare KX modifier, do we bill with KX from the beginning of the first visit or do we use it at the point of reaching the cap?**

A: You should only use the KX modifier for patients who have met the cap. Using the KX modifier starting from the first visit for any patient you think might exceed the cap would be an audit red flag.

**Q: At the point a Medicare patient reaches the cap, is continued treatment based on medical necessity or is there a limit to the number of visits after that point?**

A: As long as the patient qualifies for an exception based on Medicare regulations or requires therapy services that would be deemed medically necessary (not maintenance therapy), service can continue regardless of cost. There is no set limit on the continued treatment.

**Q: If a patient has a chronic condition that fits one of the exceptions like Parkinson's, RA, or CVA, is it possible to treat them more than once in the year if they have a decline in function? For example, treat for 12 visits and D/C then 2-3 months later they demonstrate a decline and the physician refers them back for additional therapy.**

A: As long as the therapy services provided meet the definition of medical necessity, service could continue throughout the year.

**Q: The diagnosis of abnormal gait is used frequently and it is on the exemption list. What are the resources for defining this diagnosis? What are the most important areas of documentation?**

A: Resources one could use to help define and better understand when to code for gait abnormality include the AMA CPT Code Guide Book, Ingenix's 2007 Coding and Payment Guide for Physical Therapists, and, most importantly, your local coverage determination.

**Q: Is the approach of billing a true secondary insurer upon exhaustion of the Medicare cap a sound one for the purposes of review?**

A: If the patient exceeds the cap and the services are medically necessary according to Medicare's definition, we would recommend you bill Medicare using the KX modifier. If the patient does not qualify for the exception and services would be covered by a secondary insurer, you could bill the secondary insurer.

### Billing and Coding Issues

**Q: I charge for everything I do whether I know it is going to get denied or not (for example, a therapeutic procedure and hot pack). I know hot pack is going to be denied but I charge for it because I did it. Is this wrong?**

A: We would not recommend charging for the hot pack. Hot packs are bundled in the payment of the service and therefore are not reimbursable. However, you should document in the medical record that the hot pack was provided to the patient.

**Q: Can you bill for an evaluation and a treatment in the same session?**

A: Yes. There are a number of CCI edits involving reevaluation and treatment. If there is a CCI edit pair, you would need to use the -59 modifier when billing these codes in the same treatment session and indicate the services were furnished in distinct time frames in your documentation.

**Q: When performing an initial evaluation I also teach the exercises while looking at the muscle endurance. Can I bill for therapeutic exercise or is that all bundled into the evaluation charge?**

A: The answer to your question depends on the service you are providing. If during the evaluation, you are conducting an endurance test, monitoring blood pressure and heart rate, then that would be considered part of the evaluation. However, if you are separately teaching the patient exercises and providing home program instruction, and the documentation supports it can be separated out, then it would be possible to bill the therapeutic exercise.

**Q: Do Medicare regulations allow us to treat more than one body part on the same day and submit a charge for each body part?**

A: The supervised and constant attendance modality CPT code descriptors are defined as including application of a modality to one or more areas. This means that it would not be appropriate to submit a charge for each body part.

**Q: Can a patient be billed for iontophoresis pads when iontophoresis treatment is delivered?**

A: No. Supplies are considered to be part of the service.

**Q: We are a physical therapy outpatient clinic and bill for strapping (taping) such as knees, wrist, elbows, etc. Is the tape considered part of the strapping code or can we bill per inch as stated in the Ingenix Coding and Payment Guide for Physical Therapy?**

A: Use of casting and strapping codes is not recommended in the examples below:

When providing taping to address proprioceptive deficits (e.g. McConnell taping, kinesiotaping). In these cases, CPT code 97112 best describes the intervention.

**Q: My question was in regard to "Unbundling". Can you please explain the "wound care code?" Are you talking about the debridement codes (97597 & 97598) or the VAC codes (97605 & 97606)? What about E-stim (97014) or Ultrasound (97035)?**

A: CPT code 97597 is defined in the 2007 Coding and Payment for Physical Therapists Guide as including the use of whirlpool. In this instance you could not bill for 97022 and 97597 or 97598 for the same patient in the same treatment session. In addition, if you bill for 97597 or 97598, 97605 and 97606 are bundled into these debridement code and could not be charged in the same visit. The wound care codes are listed below.

97597 Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g. high pressure water jet with/without suction, sharp selective debridement with scissors, scalpel, and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use whirlpool, per session; Total wound(s) surface area less than or equal to 20 sq cm

97598 total wound surface area greater than 20 sq cm

97602 removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g. wet-to-moist dressings, enzymatic abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

97605 Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 sq centimeters

97606 Total wound(s) surface area greater than 50 square centimeters

The electrical stimulation CPT code (97014) includes disposable electrodes. This code can only be billed once per visit per patient regardless of the number of body areas or application times.

**Q: When the diagnosis code provided by the physician is not listed on the Medicare 'Medically Necessary' code list how do we as PT's submit a corresponding diagnosis code that is acceptable for Medicare payment and not returned as a denial when linked to specific procedure codes such as 97110 and 97140. For example: 847.2 Lumbar Strain on the physician referral is not on Medicare**

list as acceptable but Lumbago is listed as an acceptable Medicare referral. My understanding of Medicare guidelines reimbursement for PT is based on diagnosis codes which are deemed medically necessary.

A: A physical therapist should always evaluate the patient and use the appropriate physical therapy diagnosis code based on the ICD-9 and CPT codes covered through their local coverage determination.

### Claims Processing

**Q: Medicare guidelines require PTs to use Modifiers for billing. Where can I find a complete list and description of these Modifiers?**

A: The modifiers that PTs primarily use are: KX (for therapy cap exceptions), GP (to indicate services are provided under a therapy plan of care), -59 (for CCI edits to indicate services were performed in separate and distinct time frames). Information regarding coding is available on APTA's website at: <http://www.apta.org/AM/Template.cfm?Section=Coding&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=59&ContentID=16527>

**Q: If you are seeing a Medicare patient who is fortunate enough to have a true secondary insurance which will reimburse in full once the Medicare cap is met as long as Medicare has produced a denial:**

- Is there a special modifier to use in this situation when all that you seek is a Medicare denial?

A: The GY modifier.

- Is it necessary to use such a modifier when all that you are looking for is a denial?

A: Yes.

- Are the denied visits, considering they may signify a more prolonged duration of treatment, scrutinized as Medicare visits for the purpose of review?

A: No.

**Q: If we have a PT fill in for us rarely (1x in 6 months), does the substitute PT need to enroll as a Medicare provider before our clinic can bill for those services? Or can we bill under the NPI of the PT that established the plan of care?**

A: The substitute PT should be enrolled as a Medicare provider, bill under his/her PT NPI number and reassign payment to the practice. You should not bill under another PT's NPI number.

### Non-participating Providers

**Q: We are non-participating providers for Medicare. Can we accept cash at the time of service to cover the payment for the visit? Our understanding is that we can accept cash payment for the co-pay and the date of service.**

A: Non-participating providers collect payment in full from the Medicare beneficiary; submit the claim on the beneficiary's behalf and Medicare will directly reimburse the patient.

### **Aquatic Therapy**

**Q: I use part of a pool at the recreation center that I rent. I cannot rent out the whole pool. Should I stop seeing my Medicare patients for aquatic therapy?**

A: "If services are furnished in a private practice office space, that space shall be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. For example, a therapist in private practice may furnish aquatic therapy in a community center pool. As required in other settings (such as rehabilitation agencies and CORFs), the practice would have to rent or lease the pool for those hours, and the use of the pool during that time would have to be restricted to the therapist's patients, in order to recognize the pool as part of the therapist's own practice office during those hours."

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> (pg. 166)

**Q: Could you please clarify the regulation on having more than one person in the pool at any given time?**

A: You can have multiple people in a pool at one time, but the pool must be used exclusively for patients. In other words, according to CMS you could not have your patients in one portion of the pool while members of the community who have memberships to the pool use another section.

### **Inpatient Rehab Facilities: 75% Rule**

**Q: What is the 75% rule mentioned in the lecture and the questions?**

A: The 75% rule applies to inpatient rehab facilities. It states that for a hospital to be considered an inpatient rehabilitation facility (IRF) the hospital must serve an inpatient population of whom at least 75% required intensive rehabilitative services for treatment of one or more of 13 conditions specified. If this condition is not met, reimbursement will be based on the acute care hospital rate. More information on the 75% rule is available at

<http://www.apta.org/AM/Template.cfm?Section=Hospitals1&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=40691>

### **Skilled Nursing Facility**

**Q: The slide titled "Risks Specific to SNFs" has a point about PTA's completing MDS. I did not hear or missed the comments in regards to this issue. Can you explain the details of this point?**

A: It is APTA's view that a PTA does not provide evaluations and that the MDS form is somewhat analogous to an evaluation in that it involves drawing conclusions about the patient's condition. However, there may be sections of the form that involve objective observations that may not require a physical therapist.

## Home Health

**Q: If patients are still receiving Home Health care when the outpatient PT services were rendered, how are the patients still considered Home Bound patients?**

A: If the patient is leaving his/her house frequently, the beneficiary may not be meeting the definition of homebound. A beneficiary will be considered to be **homebound** if the beneficiary has a condition due to an illness or injury which restricts ability to leave the residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if the beneficiary has a condition which is such that leaving home is medically contraindicated. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay.

An individual does **not** have to be bedridden to be considered as confined to home. However, the condition of these patients should be such that there exists a normal inability to leave home and consequently, leaving their home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered **homebound** if the absences from the home are infrequent or for periods of relatively short duration. It is expected that in most instances, absences from the home will be for the purpose of receiving medical treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block, or a drive to attend an infrequent or unique event (i.e., funeral), would **not** necessitate a finding that the individual is not **homebound** if absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the healthcare provided outside rather than in the home. These examples are **not** all-inclusive and are meant to be illustrative of the kinds of infrequent or unique events a patient may attend.

**Q: Why does Medicare penalize the Part B PT providers if a patient is under a home health plan of care?**

A: Medicare has a consolidated billing requirement in home care. Therefore, a home health agency is responsible for providing all the home health services (e.g. PT, OT, nursing) that the beneficiary needs during the home health episode. The patient must be discharged from home health in order for a physical therapist to provide outpatient therapy services and bill Medicare for those services. Unfortunately, it can be difficult for a physical therapist to know whether a patient is under a home health plan of care.

**Q: Is it appropriate for an outpatient rehabilitation facility to have a contract with a home health agency to treat patients in the facility and bill the agency per visit? It is our understanding that this service is allowed due to the fact that we are able to provide equipment and services such as aquatic therapy that the agency is unable to offer.**

A: It may be possible for a patient under a home health plan of care to receive services elsewhere as long as the home health agency is responsible and the other practice setting does not bill Medicare for the services. CMS recognizes that on occasion, a Medicare beneficiary may need equipment that is not available at home.

## Other Issues

**Q: Is it necessary to follow the Medicare policy guidelines for patients enrolled in a Medicare Advantage Plan and not traditional Medicare?**

A: A provider would have to meet the Medicare conditions of participation. But, for the most part, the answer is no. Medicare Advantage Plans will develop their own guidelines.