Driving Forces of Change

Current System Unsustainable

- Sustainable Growth Rate (SGR) – Basis for formula used to determine Medicare Physician Fee Schedule
  - unsustainable into future
- Therapy Cap and call for an "Alternative Payment System" initiated in 1997's Balance Budget Act
- Downward spiral of payment with increase in administrative burden (cost)

Fee Schedule Payment

- Potential for significant increase number of insured individuals
- A "Premium" on Right Provider in the Right Role for the Right Patient at the Right Time
- A need to show Value / Quality / Outcomes related to Physical Therapy services as part of delivery systems and reform models

Preventing Effectively for Outpatient Payment in 2013 & Beyond

AGENDA

- Navigating third party payment environment in 2012-2013
- Expectations for 2013 Medicare Fee schedule
- Therapy cap and other potential policy changes
- Fraud & Abuse and Current Audit Activity
- CPT and ICD-9 Diagnosis reporting
- Compliance: Documentation and Medical Necessity
  - The reviewer’s perspective
  - Medical Necessity, skilled care and focus on function
  - Developing functional goals
- EMR’s: Common Audit Flags
- Medicare Documentation Requirements & Third Party Applications
- Q & A Panel
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Focus on the 97000 Code Set
Rehab Providers

<table>
<thead>
<tr>
<th>Volume</th>
<th>• Decade of Rapid Growth (Services and Users)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variance</td>
<td>• Little consistency of services across Providers, increase in Fraud/Abuse, Lack of Data</td>
</tr>
<tr>
<td>Value</td>
<td>• Currency of Participation, to patients and payers, providers role in system</td>
</tr>
</tbody>
</table>

Distribution of Spending (Part B)

An Unsustainable Payment Environment

Medicare Updates 2013

Payment Challenges Ahead in Outpatient Payment

Medicare Physician Fee Schedule Updates
- February 17 Congress passed Legislation that freezes any further changes to fee schedule through 12/31/12
- Cap Exceptions process authorized through 12/31/12, Adds OP Hospital beginning Oct. 2012
- Fee Schedule update cuts averted by Congressional action, remaining impact on PT services a positive 4% (practice expense)
- Medicare update and therapy cap exceptions cost $20-22 billion

Payment Challenges in Outpatient Rehab Payment
Fee Schedule Rules for Medicare - 2012

Changes in Therapy Cap Methodology-OCTOBER
- 1880.00 Therapy Cap will also apply to hospital setting October 3, 2012
- Cap is per beneficiary, PT/SP share cap amount, OT has a separate cap amount, cumulative back to Jan. 1
- Cap Exceptions (benefit is medically necessary past $1880.00 amount) applies in all OP settings
- Once benefit paid up to $3700.00, manual review of request for continued care and payment under benefit
Therapy Cap
Automatic Exceptions: $1880.00

Clinically complex conditions and situations can justify an automatic exception for ANY condition if directly and significantly impacting the rate of recovery for the condition being treated

- Document both the condition being treated and the appropriate complexity (ICD-9 or situation)
- Document why/how the complexity affects treatment (i.e.; cardiac diagnosis affecting pace of progress with musculoskeletal diagnosis)

Coding Challenges and Practice Implications
Therapy Cap and Exceptions Process

- Situations could include; discharge from an IP facility within 30 days of Therapy IE/POC, receiving Speech therapy at same time as OT or PT, returning for PT/OT/SP care following a DC from the same discipline within that year
- Describing why/how the complexity affects treatment (i.e.; cardiac diagnosis affecting pace of progress with musculoskeletal diagnosis)

Therapy Cap
Manual Review Process: $3700.00

- Providers will be phased into this requirement:
  - Phase II Nov. 1-Dec.31, 2012
  - Phase III Dec. 1-Dec.31, 2012
- Assignment of phases: provider NPI, history of reporting of KX and MAC workload
- No automatic exceptions based on a reported Diagnosis
- MAC's will refer to Benefit Policy Manual and LCD's to make decisions on requests for continued care
- Requests for exceptions can be for increments of up to 20 visits and request should be made prior to delivery of service

HCPCS Modifiers
Coding Challenges and Practice Implications
Medicare Applications

Modifiers required when billing Medicare to indicate the benefit under which the Plan of Care is being provided:
- GP Physical Therapy
- GO Occupational Therapy
- GN Speech Therapy

Therapy Cap Billing Modifier:
- KX Reported with medically necessary procedures billed after the therapy cap has been reached
- If the appropriate HCPCS modifier is not placed on claim with each CPT code reported, payment could be delayed or denied
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Payment Challenges in Outpatient Rehab Payment
Changes in Therapy Cap Methodology

Resources: CMS
Overview of therapy cap
- Overview of Medical Review Process (@ 3700.00)

Payment Challenges in Outpatient Rehab Payment
Changes in Therapy Cap Methodology

Resources:
Overview of therapy cap

October updates to therapy cap
- http://www.apta.org/LegislativeAction/

Payment Challenges in Outpatient Rehab Payment
Fee Schedule Rules for Medicare - 2013

In anticipation of proposed rule to be published
- Therapy Cap to increase (legislative) ~ 10%
- Application to hospital setting will be reviewed first quarter with, Impact beyond that ?????
- Exceptions process anticipated to be extended to allow bridge for alternative payment models to be vetted
- Manual review process (3700.00) could extend into 2013
- CMS to add requirement to report functional change based on the documented POC and goals

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Payment Challenges in Outpatient Rehab Payment

Fee Schedule Rules for Medicare - 2013

In anticipation of proposed rule to be published
- CMS to add requirement to report functional change based on the documented POC
- At IE, Internim visit (10th), and at DC
- To describe principle functional limitation, impact on up to 4 ICF categories of function
- Potentially, the complexity level of the patients presentation (low, moderate, high)
- The Percent of functional change with care
- Informed by a functional measurement tool of therapists’ choice (Oswestry, Berg, 6 min. walk test)

Potential Categories for Reporting Functional Limitations

<table>
<thead>
<tr>
<th>Medicare</th>
<th>G-Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking &amp; Moving - Arthritis</td>
<td>G0330</td>
</tr>
<tr>
<td>Walking &amp; moving around functional limitations, current status of initial therapy treatment status and reporting criteria</td>
<td>G0331</td>
</tr>
<tr>
<td>Changing &amp; maintaining body position, functional limitations, current status of initial therapy treatment status and discharge date</td>
<td>G0332</td>
</tr>
<tr>
<td>Changing &amp; maintaining body position, functional limitation, current status of initial therapy treatment status and discharge date</td>
<td>G0333</td>
</tr>
<tr>
<td>Convalescent Nursing &amp; Rehabilitation</td>
<td>G0334</td>
</tr>
<tr>
<td>Convalescent nursing &amp; rehabilitation, functional limitation, current status of initial therapy treatment status and discharge date</td>
<td>G0335</td>
</tr>
<tr>
<td>Convalescent nursing &amp; rehabilitation, functional limitation, current status of initial therapy treatment status and discharge date</td>
<td>G0336</td>
</tr>
</tbody>
</table>

Multiple Procedure Payment Reduction (MPPR)

- Current Medicare Application: Full payment for the therapy service (unit) with the highest practice expense value and reduce payment of the practice expense (PE) component by 20% for private practice therapy offices and physician offices, 25% for facility based providers for the second and subsequent units of service furnished during the same day for the same patient
- Applies to therapy services when multiple therapy services are billed on the same date of service for the same patient by the same practitioner or facility under the same NPI, regardless of whether those therapy services are furnished in separate sessions.

Coding and Payment Policy Challenges

CCI Edits

- Pairs of CPT codes that when reported together are not separately payable except under certain circumstances
- Edits are applied to services provided by the same provider for the same beneficiary on the same date of service
- All edits are incorporated into one list, published quarterly

Coding and Payment Policy Challenges

CCI Edits and Use of Modifiers

Use of the -59 modifier:
- Indicates a distinct procedural service separate location of treatment, separate patient encounters or separate session on same day
- Inappropriate use of modifiers not justified by the clinical circumstances, constitutes fraud
- Documentation to support use of modifiers is crucial
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CCI Mutually Exclusive Table

Coding and Payment Policy Challenges
Examples of CCI Edits for PM&R Codes
Be aware of CCI Edits that cannot be modified;
- 97001 or 97002 with 97750 or 97755

Edits that are able to be reported with 59 Modifier;
- 97002 with 97110 (and other direct contact/timed codes)
- 97110 and 97113
- 97116 with 97530
- 97140 with 97530
- 97150 with 97110 (and other direct contact/timed codes)

The Future...It Ain’t What It Used To Be.....
Impact On the Commercial Payer

Coding and Payment Policy Challenges
Resources for CCI Edits
CCI Edits available on CMS website;
Two versions, One list of CCI edits
- Carrier (office-based providers) published earlier
- Intermediaries (Rehab, Hospital and other facility OP providers) being one version behind that applied by carriers
- http://www.cms.gov/NationalCorrectCodInitED/

Trends in Payment
Commercial Payer Policy
- Taking page out of Medicare’s playbook in setting fees
- Developing innovative Models of care and Payment
  - Case rates
  - Episodic care
  - Value Based, Pay for performance
- Coverage of services by PTA’s (and other extenders) at risk
- Audits-retrospective based on claims trends (units/Dx)

Trends in Payment
Federal Payers
- Pressing Need for Reform
  - Medicare program is carrying 24.6 trillion “unfunded liabilities” thru 2085
  - “Answers” are all across the spectrum:
    - Independent Payment Advisory Board (IPAB)
    - (resource: Kaiser Family Foundation, kff.org, PDF explaining IPAB)
    - Accountable Care Organizations
    - Bundling of Services
- Not “when” but “how”...will change come about?
  - APTA efforts to develop per visit/session based payment methodology for reporting and paying for PT/OT services
  - Timeline: 2015
Common Theme to Healthcare Initiatives  

Need to Prove Value of Rehab

- Value-based health aims to improve quality, lower costs, and drive toward value in healthcare delivery
- The demand for value requires greater accountability on the part of all stakeholders within healthcare

Identification of best practices  
Provider adherence to best practices  
Measurement of provider performance  
Benefit design  
Cost-effectiveness

VALUE

Payment for Physical Therapy Out-Patient Services  
Pressing Need for Reform

Alternative Payment System

- APTA Developing a Reformed Payment model
- Based on Clinical Judgment of the PT
- Visit/Session Based System
- Factors include the severity and complexity of the patients presentation with the added dimension of the required intensity and complexity of the therapists clinical clinical decision making and expertise
- Other Stakeholders (AOTA) reviewing from their practice context

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Therapy Services: Under Intense Scrutiny...

Are We Asking For The Scrutiny?  
Unwarranted Variation in Practice

Variation in Provider practice styles:

- Root cause of excessive and inappropriate healthcare utilization, resulting in less-than-optimal quality and efficiency
- Reflects the “unique approach” provider takes when recommending care, especially when there is a lack of consensus about what care is best in a given situation
- Result in part, from sheer amount of scientific evidence published each year to sift through in order to;
  - Focus on “evidence-based” healthcare
  - Difficult for even most conscientious provider to keep up!

Are We Asking For The Scrutiny?  
Unwarranted Variation in Practice

Variation in Provider practice styles:

- Culture or style of the Practice and related influences are often a key component
  - Organization dictates change of practice
  - Simply habit – “the way it has always been done”
  - Following the latest, greatest “guru”
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Variation in Provider practice styles:
- Notes from Congressional Budget Office (July 2008)
  - Variation in healthcare spending primarily results from variation in the intensity of services provided
  - Higher spending not associated with better health outcomes than in areas with lower spending
  - Expanded use of Health Information Technology (HIT) has potential to improve quality and efficiency of care provided while reducing overall cost

Three types of inappropriate care that have a negative impact or quality and efficiency in the U.S. Healthcare system:
- Overuse
- Underuse
- Misuse

Overuse of healthcare services occurs when:
- Risk of providing a service exceeds the benefits of receiving that service
- Services are ineffective, therefore inappropriate
- Occurs when the benefits of additional services do not justify their costs: More is not necessarily better!
- Services may be comparatively ineffective – alternate, lower cost services available that yield better benefits
- Negative consequences:
  - Exposes patients to unnecessary risks of complications, increases healthcare costs with no increased benefits.

Underuse of healthcare services occurs when:
- Services known to be medically beneficial (have evidence) are not provided
- NEJM Study examined healthcare quality for acute and chronic conditions found that patients received about 50% of recommended services (reference: NEJM Study)
- Negative consequences:
  - Underuse may cost less in the short term, however lack of immediate appropriate care targeted at corrective and curative treatment for acute conditions can result in worsening of such conditions, increasing costs over the long term

Misuse of healthcare services includes:
- Incorrect diagnoses and lack of attention to patient safety considerations
- Excessive or unnecessary utilization of health services by patients or providers (e.g., length of stay duration)
- Negative consequences:
  - Contributes significantly to rising health care costs
  - No contribution to overall improvement of quality or outcomes of care
  - Use of patients third party benefit with inappropriate care that is not evidence-based care (benefit exhaustion)

Negative consequences of poor or no documentation:
- Reflection on the profession is negative by the payer community
- Benefits limited and administrative requirements to get paid increase
- Unable to demonstrate the value of physical therapy
- Ultimately becomes more difficult to argue the cost/benefit for our services, and benefits are limited and/or payment rates decline
Fraud Defined

- Knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Abuse Defined

- That which may directly or indirectly result in unnecessary costs to the Medicare or Medicaid program, improper payment, or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary
- Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment
Civil Statutes

False Claims Act: 31 U.S.C. §3729(b)
Knowing and Knowingly defined:
- Has actual knowledge of the information;
- Acts in deliberate ignorance of truth or falsity of information; or
- Acts in reckless disregard of the truth or falsity of the information, and no specific intent to defraud is required.

Who is Conducting Audits and Investigations?
- Medicare Administrative Contractors (MAC)
- Quality Improvement Organizations (QIO)
- Program Safeguard Contractors (PSC)
- Zone Program Integrity Contracts (ZPIC)
- Comprehensive Error Rate Testing Program (CERT)
- Recovery Audit Contractors (RAC)
- Special Investigative Units (SIU) (Private Payers)
- Office of Inspector General (OIG)
- Department of Justice (DOJ)

Overview of Audit Activity
Program Integrity
- Increased coordination of review efforts among Agencies:
  - CMS, OIG, DOJ, FBI
- Increased use of Program Safeguard Contractors (PSCs), Zone Program Integrity Contractors (ZPICs), Recovery Audit Contractors (RACs),
- Increased focus on review of physical therapy services
- Shift in focus from retroactive data to “real-time” data

Civil Statutes

False Claims Act: 31 U.S.C. §3729(b)
Reckless Disregard:
- An act of proceeding to do something with a conscious awareness of danger, while ignoring potential consequences of doing so.
Overview of Audit Activity
Prepayment Review

- Small Business Jobs Act of 2010 required predictive modeling to identify and prevent improper payments
- CMS contracted with Northrop Grumman to begin using predictive modeling technology and use real-time data to spot suspect claims and providers
- Deploy algorithms and an analytical process to look at claims by beneficiary, provider, service origin, and other patterns
- Beginning July 1, 2011, identify potential problems and assign an “alert” and risk scores for claims that are aberrant

If documentation review identifies services are not medically necessary, payment will be denied
- The review process itself will result in delays in payment
- Cash flow can be significantly affected as a result
- Provider can appeal determination to the MAC in the event of any denials
- National Government Services (NGS), Palmetto GBA, and First Coast Service Options (FCSO) have initiated an increased number of prepayment reviews of physical therapy practices

Overview of Audit Activity
Prepayment Review

- MACs/ZPICs are targeting providers with claims that have particular patterns of billing:
  - Excessive use of KX modifier
  - More units billed by one provider than reasonable
  - More units per visit (direct contact) than expected (4-5)
- For prepayment review, contractors typically requesting documentation from 5 claims to review for medical necessity
  - If problem identified, will request additional medical records
  - If documentation does not support medical necessity, MAC may place provider on 100% prepayment review

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Types of Claims</th>
<th>How Selected</th>
<th>Type of Review</th>
<th>Purpose of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERT</td>
<td>All Medical Claims</td>
<td>Randomly</td>
<td>Prepay only Complex only</td>
<td>To measure improper payments</td>
</tr>
<tr>
<td>Medical Review Units at MACs</td>
<td>All Medicare FFS Claims</td>
<td>Targeted</td>
<td>Prepay and Postpay Automated and Complex</td>
<td>To prevent future improper payments</td>
</tr>
<tr>
<td>MAC</td>
<td>All Medicare FFS Claims</td>
<td>Targeted</td>
<td>Prepay only Automated and Complex</td>
<td>To detect and correct past improper payments</td>
</tr>
<tr>
<td>PSC/ZPICs</td>
<td>All Medicare FFS Claims</td>
<td>Targeted</td>
<td>Prepay and Postpay Automated and Complex</td>
<td>To identify potential fraud</td>
</tr>
<tr>
<td>OIG</td>
<td>All Claims</td>
<td>Targeted</td>
<td>Postpay Complex</td>
<td>To identify fraud</td>
</tr>
</tbody>
</table>

Overview of Audit Activity
Zone Program Integrity Contractors

- Hired indirectly (or in connection with other CMS affiliated contractors) by CMS to perform a wide range of medical review, data analysis, and Medicare audits.
- Similar to other Medicare audits but differ in one very important aspect – potential Medicare fraud implications.
- Combine data from a number of different sources to create a platform for complex data analysis.
- Use data to look for overpayments and potential fraud
- ZPICs refer all identified overpayments to the MAC, who sends the provider a demand letter for recoupment
  - May conduct site visits
  - May refer cases to OIG, FBI, DOJ, etc.

Overview of Audit Activity
Zone Program Integrity Contractors

- Seven zones based on MAC jurisdictions
- Five “Hot Spot” Zones
  - California, Florida, Illinois, New York, Texas
  - Align with Program Integrity field offices
- ZPICs focus on quick response to fraud and administrative actions
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Overview of Audit Activity
Zone Program Integrity Contractors

Zone 1: CA, NV, HI, American Samoa, Guam, Mariana Islands - Safeguard Services
Zone 2: AK, AZ, ID, KS, MO, MT, ND, NE, OR, SD, UT, WA, WY - AdvanceMed
Zone 3: IL, IN, KY, MI, MN, OH, WI - PSC
Zone 4: CO, NM, OK, TX - Health Integrity, LLC
Zone 5: AL, AR, GA, LA, MS, NC, SC, TN, VA, WV - AdvanceMed
Zone 6: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT - PSC
Zone 7: FL, PR, VI - Safeguard Services

Overview of Audit Activity
Fiscal Year 2010 Estimated Improper Payment Reported Amounts

- 27% ($34.3 billion) Medicare Fee-for-Service
- 11% ($13.8 billion) Medicare Advantage
- 62% ($77.5 billion) Other federal programs

Source: GAO summary of agency data

Overview of Audit Activity
Improper Medicare Payments

- Improper Payments:
  - Right provider/wrong service
  - Right provider/wrong payment
  - Wrong provider/wrong service
  - Wrong provider/wrong payment

- Overpayments and underpayments:
  - Do not meet statutory coverage requests
  - Do not meet the medical necessity requirements
  - Are incorrectly coded
  - Do not submit sufficient documentation

Overview of Audit Activity
Medicare

Audit can be triggered by a number of issues:
- Random audits (previously most common)
- Provider identified as "outlier"
- Third party payers notice a statistical change in billing codes or volume
- Provider identified through normal claims process (e.g. claim appealed for some reason such as to request additional payment, reviewer finds questionable items)
- Provider, employee (usually former employee), or beneficiary complaint
- Another agency (such as a referral from OIG or US Attorney as a result of some finding from a related investigation of their own)

Overview of Audit Activity
Improper Medicare Payments

- Audit activity has significantly increased
- Driven by various data and reports focused on improper payments under the Medicare program
- For FY 2010, HHS reported almost $48 billion in Medicare improper payments
- 2010 Medicare Fee for Service error rate 10.5% ($34.3 billion)
- Government goal is to reduce Medicare FFS improper payment (CERT) rate to:
  - 8.5% by November 2011
  - 6.2% by November 2012
What is CERT?

- The Comprehensive Error Rate Testing (CERT) program
- Designed by CMS to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment
- Over 120,000 randomly-selected claims are reviewed each year
- Characterize and quantify local, regional, and national error rate patterns

CERT

- Purpose:
  - Provider billing correctly
  - Contractor processing correctly
  - Contractor paying correctly
- The CERT post pay reviewers in all Medicare jurisdictions have begun to deny all reviewed claims where there was no legible signature of the provider, whether the reviewed document was a progress note, lab or imaging request, or any other element of the medical record requiring a signature.

FCSO CERT Findings

<table>
<thead>
<tr>
<th>Procedure - Descriptor</th>
<th>Error Code</th>
<th>#21 Insufficient Doc.</th>
<th>#25 Medically Unnecessary</th>
<th>#31 Incorrect Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>971.10 Therapeutic exercises</td>
<td>79.83%</td>
<td>20.17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>973.30 Therapeutic activities</td>
<td>32.79%</td>
<td>67.21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>971.40 Manual therapy</td>
<td>60.46%</td>
<td>39.54%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most common CERT related errors

- Missing total time code treatment minutes
- Missing required certification of plan of care/treatment plan
- Missing required initial evaluation
- Missing authenticated physician order for physical therapy
- Missing all prior treatment notes
- Missing treating physician progress notes
- Missing signature or illegible signature

FCSO CERT Findings

- Insufficient documentation error
  - Missing physician order for physical therapy
  - Script stated “continue PT”
  - Illegible signature
  - Progress note indicating
  - Hot/cold packs
  - Modalities as needed
  - Massage
  - Soft tissue stretching
  - Strengthening exercises
  - Home exercise program

FCSO CERT Findings

- Insufficient documentation error
  - Missing required initial evaluation with frequency and duration of therapy services
  - No physician certification of the plan of care
  - No long term goals documented
  - No treatment notes submitted
  - No progress reports
  - Missing total time code treatment minutes
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FCSO CERT Findings
CERT Error Example 3
- Physician signature issue
  - Physician order not legible
  - Office/progress notes not signed or not legible
- CERT requested signature log or attestation statement
  - No response by the provider to additional requests

FCSO CERT Findings
Prepayment MR Edit
- Services billed by physician specialties – 2011 CERT report
  - Represented 70% of dollars incorrectly paid for therapy services
  - 19% claim payment error rate (based on dollars)
- Services billed by general practice specialty
  - Represented over 12% of all therapy services billed in Florida

FCSO CERT Findings
Prepayment MR Edit (Cont.)
- Common reasons for errors
  - Insufficient documentation including failure to meet documentation requirements specific to therapy services
  - Failure to meet medical necessity

Comparative Billing Report (CBR)
- A Comparative Billing Report (CBR) is a documented analysis that shows a provider’s billing pattern for various procedures or services and compares that billing to their peers.
- The Centers for Medicare & Medicaid Services (CMS) awarded the Comparative Billing Report (CBR) contract to SafeGuard Services LLC (SGS).
- CMS has authorized SGS to begin producing nationwide CBRs beginning in 2010.
- SGS, as the CBR Producer, has begun to develop an inventory of potential topics for study.

Comparative Billing Report (CBR)
- Not intended to be punitive or sent as an indication of fraud.
- Intended to be a proactive statement to help the provider identify potential errors in their billing practice.
- Contains peer comparisons which can be used to provide helpful insights into their coding and billing practices.
- The information provided is designed to help the provider prevent improper billing and payment.
- Outpatient Physical Therapy Services billed with the KX Modifier Provided by Independent Therapists (PTPP) was identified as a vulnerability to the Medicare Program

Comparative Billing Report (CBR)
- The purpose of the CBR is to show comparative data Medicare considers when determining how a provider’s billing patterns contrast with other providers in the same specialty.
- A CBR may be a helpful tool when conducting self-audits or preparing for a seminar or medical society meeting.
- A CBR, best suited for individual physicians and non-physician practitioners, contains comparative information for all procedure codes billed.

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Comparative Billing Report (CBR)
Definitions of the 5 codes used in the CBR?
- 97110 - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
- 97140 - Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
- 97112 - Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
- 97530 - Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
- G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Comparative Billing Report (CBR)
- For the KX Modifier CBR, peers include:
  - Anyone billed with a Specialty code 65
  - Independent outpatient Physical Therapist.
  - Place of service billed: Office setting.
  - State: All physical therapists who practice in the individual provider’s state.
  - If a provider practices in more than one state, he/she was compared to the physical therapists in the state where he/she has the majority of his/her business.
  - National: All independent outpatient physical therapists in the nation.

Figure 11. Estimated therapy users within age group over cap threshold in CY 2008

Source: CSC CY 2008 Outpatient Therapy Utilization Report

Therapy Services Using KX Modifier

<table>
<thead>
<tr>
<th>Provider type</th>
<th># with KX modifier</th>
<th>% of KX usage</th>
<th>% billed with KX prior to $1500 cap</th>
<th>% billed with KX prior to $1500 cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med B</td>
<td>224</td>
<td>100%</td>
<td>224</td>
<td>100%</td>
</tr>
<tr>
<td>Med A</td>
<td>155</td>
<td>100%</td>
<td>155</td>
<td>100%</td>
</tr>
<tr>
<td>Med B</td>
<td>163</td>
<td>100%</td>
<td>153</td>
<td>100%</td>
</tr>
<tr>
<td>Med B</td>
<td>283</td>
<td>51.71%</td>
<td>136</td>
<td>100%</td>
</tr>
<tr>
<td>Med A</td>
<td>104</td>
<td>99.04%</td>
<td>103</td>
<td>100%</td>
</tr>
</tbody>
</table>

Overview of Audit Activity
Risk Areas for PTs in Outpatient Setting
- Documentation is insufficient
- Billing for services not provided (not documented)
- Services not medically necessary
- Plan of Care not signed by physician
- Plan of Care not recertified
- Signatures not legible
  - Physical therapist’s on documentation
  - Physician’s on POC
- Use of a stamped signature
- Services provided are not consistent with Local Coverage Determination (LCD) provisions
Physical Therapy - A Prime Target
Over 75% of Rehab Services Provided

Lack of Defined Scope of Practice
- Documentation has historically been insufficient in demonstrating the value of rehabilitation:
  - Does not justify medical necessity or need for skilled care
  - Typically lacks evidence of clinical reasoning
  - Inconsistent in format and content
  - Lacks evidence of measurable change in functional outcomes
- Variation in type, quality, and outcome of interventions provides third party and regulatory agencies incentive to limit coverage and payment to control their costs

OP Rehab - A Prime Target
Compelling Evidence for PT Audits

Practice Variability & Lack of Defined Scope of Practice
- Rehab used as a generic term not specific to professional scopes (PT/OT)
- Clinicians have generally not adopted the tools to provide for a basis for reflecting clinical reasoning and communication of the same...(Guide to Physical Therapist Practice, evidence based practice guidelines, or other tools.)
Overview of Audit Activity- FCSO
Therapy services billed by physicians

- Currently therapy services billed by both podiatry and general practice specialties are subject to prepayment review - prepayment review activities will be expanded to include the family practice specialty.
- Prepayment medical review edit implemented on August 28, 2012
  - Requires submission of medical records to support physical therapy services billed by family practice practitioners.

Overview of Audit Activity
Florida Blue - MCG

PT Services are eligible for coverage provided the services are:
- Rendered in accordance with a written prescribed treatment plan
- The treatment plan contains stated attainable short and long term goals
- The treatment plan includes specific modalities, including frequency and duration, that are based on the individual's diagnosis and prognosis
- Necessary to provide expected restoration of a physical function
- Rendered by a qualified licensed professional (physician, physical therapist, chiropractor) as an integral part of a treatment plan
- For continued therapy, the treatment plan must be recertified by the physician at least every 60 days*

Medical Coverage Guideline (MCG), approved by BCBSF Medical Policy & Coverage Committee on 3/25/11, *Revised 8/15/11

Physical Therapy at the Center
Case: Florida; Payer: Medicare (FCSO)

Audit Activity:
- Statistically aberrant claims data compared to peers (aquatic)
- Probable Review of 40 claims over 6 month period (141 services for 32 beneficiaries)
- High Error Rate; provider placed on 100% prepayment review

Issues:
- Services not consistent with LCD Guidelines (L29289)
- Lack of improvement; lack of documented medical necessity
- Provider on claim form different than on medical record
- Lack of support for aquatic therapy (97113)
- Closed documentation

Outcome:
- Continues under prepayment review (since March 2012)
- Unable to get information from SGS
- FCSO and SGS appear not to be communicating with each other

Physical Therapy at the Center
Case: Florida; Payer: Medicare (FCFOS)

Audit Activity:
- CMR revealed aberrant billing pattern for 97110 and 97140
- Probe medical review as part of Medical Review Progressive Corrective Action (PCA) [2008] – 100% error rate
  - 40 claims over 6 months; 358 services for 10 beneficiaries

Issues:
- ADL limitations not specifically identified or addressed
- None of LTGs were measurable or objective (related to function)
- Services billed with KX modifier but not supported in documentation
- All patients received manual therapy but no documentation to support
- Functional limitations not documented in objective/measurable terms

Outcome:
- Satisfied PCA Probe; Prepay review suspended after education and demonstrated improvements
- Statistical Sampling Medical Review July 2011 to follow up on 2008 Probe Review – to look back to 1/1/07 to 12/31/07 Documentation!

Physical Therapy at the Center
Case: Florida; Payer: Medicare (FCFOS)

Audit Activity:
- May 2011 – placed on 100% prepayment review without warning
- Hired consultants, education and training, removed from prepay review August 2011
  - March 22, Notice of Probe Review; High error rate, Prepayment review begins May, 2012

Issues:
- Lack of measurable functional limitations
- Lack of evidence of need for skilled care
- Performing provider on claim form different from documented
- Documentation did not support LCD guidelines (L29289)

Outcome:
- Multiple educational calls with FCSO staff; lack of timely responses
- Notification provided September 4, 2012 of prepayment review termination

Physical Therapy at the Center
Case: Florida; Payer: Medicare (FCFOS)

Audit Activity:
- March 2011 – placed on 100% prepayment review with warning

Issues:
- Documentation of medical necessity for services billed by physical therapist
- Services billed with KX modifier but not supported in documentation
- All patients received therapy but no documentation to support
- Functional limitations not documented in objective/measurable terms

Outcome:
- Satisfied PCA Probe; Prepay review suspended after education and demonstrated improvements
- Statistical Sampling Medical Review July 2011 to follow up on 2008 Probe Review – to look back to 1/1/07 to 12/31/07 Documentation!

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CPT Coding Guidance

WOW, I could have reported a 97002

CPT Code Structure and Process

Reportin PT/OT Services

- Primarily 97000 series, 48 descriptors
- Codes are not provider specific
- Evaluations, supervised modalities, group procedures and wound care procedures do not include any time component in their descriptors
- All other modalities and procedures are time based and require provider documentation to support units billed
- Other codes in CPT reported by PT/OT include:
  - Medical Team Conference, Non physician non face-to-face services, neurology and neuromuscular procedures, Biofeedback and casting codes

CPT Code Update

Intro Language PM&R

Physical Medicine and Rehabilitation: 97000 Series

- CPT introductory language to PM&R codes applies to all services included in code set
- "The work of the qualified healthcare professional consists of face to face time with the patient (caregiver, if applicable) delivering skilled services. For the purpose of determining the total time of a service, incremental intervals of treatment at the same visit may be accumulated."

AMA CPT 2012, Pg 523, Professional Edition

Important Considerations when Coding

Consider:
- Third party reporting requirements/policies
- Use of support personnel
- Scope of Practice/Practice Act
- Edits on claims
- Professional Practice Guidelines
- And...knowing the cost of doing business

Reporting CPT Codes on a Medicare Claim

Regulation, Policy and Guidelines

- Medicare defines "Qualified Provider"
  - PT, PTA's under appropriate supervision defined as such in 42 CFR section 484.4, from August 1989 (prior to '89 another section CFR)
  - Conditions of Participation, CMS manual system, Pub 100-07
  - Medicare billing and assistive personnel
  - Treatment considered for reimbursement when skilled care provided/documented by or under the supervision of a "qualified provider"

References:
- www.apta.org
- www.cms.hhs.gov/physicalltherapy
Reporting CPT Codes on a Medicare Claim

**Regulation, Policy and Guidelines**

**Assistive Personnel and Medicare**
- PTAs can provide and report covered services under supervision as required by the setting in which the services are provided.
- PTAs may not provide evaluation services, and must work within the scope of the plan for care as defined by the PT.
- The services of a PTA shall not be billed as services "incident to" a physician/NPP's service, as they do not meet "qualified provider" definitions.
- PTAs can discharge a Medicare patient from an episode of care if under the appropriate direction of PT (within 3 visits of last PT interaction).

**Coding Challenges and Practice Implications**

**Evaluations**
- Current structure includes two "service based" codes.
- Do not reflect any specific level of complexity or severity.
- Supported by evaluation and examination that is described in the Guide to Physical Therapist Practice.
- Under MPPR, have highest PE of 97000 codes.
- 97001 Physical Therapy Evaluation
- 97002 Physical Therapy Reevaluation
- 97003 Occupational Therapy Evaluation
- 97004 Occupational Therapy Reevaluation.

**Use of Support Personnel by Physical Therapists**
- Private payer trend is to follow Medicare policy, but this should be verified with the third party payer and your state rules and regulations.
- Although an aide may assist the therapist by providing unskilled services, those services are not covered by Medicare and should not be billed.
- Typically, third party payers follow Medicare policy regarding use of aides as not reasonable and necessary care if they have been billed as therapy services.
- Joint Commission implications?
- State Law, Practice act implications?
- Provide for PT to make decision and document to support, regarding direction of care to support personnel?

**Coding Challenges and Practice Implications**

**Evaluations**
- **Documentation Checklist:** Plan of Care
  - Plan of Care reflects the culmination of the evaluation process.
  - Primary treating diagnosis.
  - Co-morbidities or issues that may affect length of care or frequency of care.
  - Active treatment interventions selected to address patients needs related to injury, illness, condition.
  - Long term functional goals, in measurable terms, with anticipated timeframe to accomplish.
  - Frequency and duration of care.
  - Reflect payer requirements (re; evidence of physician involvement with/Medicare).

**Differentiating with Documentation**
- **Initial Evaluation 97001**
  - New treating diagnosis.
  - Each episode of care starts with IE and ends with DC.
  - Evaluation and Treatment typically reported on same DOS.
  - Check published payer policy re; reporting more than once in benefit year.
  
- **Re-evaluation 97002**
  - Significant change in patient presentation (adding diagnosis, adjacent body part).
  - Addresses progress or lack of progress, by modifying POC.
  - Functional Goals update.
  - Change in duration.
Coding Challenges and Practice Implications

**Re-evaluations, Progress Notes and Certifications**

- Differentiating with Documentation
  - Re-evaluation 97002
  - Significant change in patient presentation (adding diagnosis, adjacent body part)
  - POC is modified based on progress or lack thereof that is reported
  - Functional Goals update, change in duration,
  - Billable if documentation supports
- Progress Notes
  - Not billable, part of documentation requirements, snapshot of patient at the time
  - Medicare requires note of progress at 10th visit (from IE) or at 30th day of plan of care whichever comes first
  - Could incorporate into a treatment note, documented as a separate note or part of a re-evaluation document.

**Evaluations**

- Evaluations: Professional Considerations
  - Evaluation is key to achieving a successful outcome for patient
  - Drives management of patients care
  - Assessment is the ongoing process that is determined through documenting patient’s responses to care
  - Potential for future payment methodology to be driven by evaluation/re-evaluation
  - Recognize need for coding structure to provide opportunity to discern evaluations based on complexity and severity of patients

**Documentation of Evaluation and Plan of Care**

- Organize flow of evaluation process:
  - Reason for referral
  - Relevant medical history
  - Functional status: previous, current and potential for return
  - Measure impairment, activity restrictions, and outcomes
  - Describe goals from functional perspective
  - Plan for achieving outcome of return to function

**Separately Reporting Other Test and Measurement Procedures**

- 97750 Physical performance test or measurement (e.g. musculoskeletal, functional capacity) with written report, each 15 minutes
- Document: Protocol, data collected, and impact on patient plan of care, time spent with patient
- Coding Issues:
  - Reporting this timed code in place of evaluation codes problematic
  - Use of 95000 series (muscle testing/range of motion)
  - CCI edit does not allow 97750 to be reported same day as evaluations
Coding Challenges and Practice Implications

Evaluations

Quick Tips: Coding Evaluations/Test & Measures

- Payment policy regarding treatment on same DOS as evaluation/re-evaluation
- Reporting evaluation services in context of a break in care or new problems/complaints
- Test and measures: separately coded or is the service “part” of evaluation
- Reporting specific codes that describe other testing procedures (i.e. neurology, pulmonary)

Supervised Modalities

“Application of a modality that does not require direct (one on one) patient contact by the provider”

97010 Application of a modality to one or more areas; hot or cold packs
97012 traction, mechanical
97014 electrical stimulation (unattended)
97016 vasopneumatic devices
97018 paraffin bath
97022 whirlpool
97024 diathermy
97026 infrared
97028 ultraviolet

Document Checklist:

- Document the type/parameters of the modality and the desired effect of application
- Document to support continued application (clinical decision making) over the course of the episode, specifically re: frequency and duration of application

Preparation of Submitting Modalities

Common reporting issues:

- Electric Stimulation: differentiating supervised vs. constant attendance (upcoding)
- Anodyne, Laser and , multiple effect modalities (unlisted codes)
- Iontophoresis (limitations of payer policy)
- Phonophoresis (report mechanism of delivery)
Therapeutic Procedures And Reporting Time

Medicare Payment Policy

Use to assist in reporting total treatment time as follows (with documentation to support):

- 1 unit: > 8 minutes to < 23 min.
- 2 units: > 23 minutes to < 38 min.
- 3 units: > 38 minutes to < 53 min.
- 4 units: > 53 minutes to < 68 min.
- 5 units: > 68 minutes to < 83 min.
- 6 units: > 83 minutes to < 98 min.
- 7 units: > 98 minutes to < 113 min.
- 8 units: > 13 minutes to < 128 min.


Effective Follow-Up Treatment Documentation

Follow-up visits that describe therapist involvement

- Document the time to support the units billed when reporting time-based codes
- Time reflects the therapist/assistant work not the patient’s participation
- Flow sheets are part of the legal record and need to reflect skill and have the proper identification of patient and provider signatures
- Flow sheets/documentation should describe therapists interactions with the patient and the intervention being provided and help to support units billed for timed procedures documented

Reference: CMS Benefit Policy Manual, Ch. 15, sections 220-230

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Therapeutic Procedures And Reporting Time

**Medicare Payment Policy**

**Documentation and reporting of timed codes:**
Total treatment time is all performed with direct (one on one) contact.

- **Example:**
  - Total treatment time: 28 minutes
  - Amount of direct contact time: 10 minutes of (97110) therapeutic exercise, 10 minutes of (97140) manual therapy, 8 minutes (97035) ultrasound
  - Total Direct (timed code) treatment time: 28 minutes
  - Number of units reported = 2


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**Therapeutic Procedures And Reporting Time**

**CPT (AMA) Guidance**

**Documentation of time-based codes**
- Report total time required to provider to perform all aspects of the service
- Inclusive of pre-, intra-, and post-service work

Reference: AMA CPT Assistant Publication, November 2001, August 2005

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**Therapeutic Procedures And Reporting Time**

**Medicare Payment Policy**

**Documentation and reporting of timed codes:**
- A direct contact treatment time is less than 8 minutes;

**Example:**
- Total treatment time: 40 minutes
- Direct (timed code) contact time: 33 minutes of (97110) therapeutic exercise, 7 minutes of (97035) ultrasound
- Total Direct (timed code) contact time: 40 minutes
- Total number of units reported = 3


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**Therapeutic Procedures And Reporting Time**

**Additional Guidance**

AMA CPT Manual Reference:

"The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement, unless there are code or code-range specific instructions...Time is the face to face time with the patient.

A unit of time is attained when the mid-point is passed"

Introduction CPT 2012, Page viii, Professional Edition

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**Therapeutic Procedures And Reporting Time**

**Additional Guidance**

**Documentation of time-based codes**

- Suggested commonly through third party payer policy:
  - A substantial amount of time (at least half of the timed increment) should be provided and documented to bill for the associated units of time
  - Recommend checking third party payment policies for additional guidance, many do follow CMS guidance on documentation and coding of these services
  - The billing of units and the total timed code treatment minutes documented should be consistent.

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**Preparation Effectively for Outpatient Payment in 2013 & Beyond**

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Therapeutic Procedures
Coding Challenges and Practice Implications

CPT Introductory Language

"A manner of effecting change through the application of clinical skills and/or services that attempt to improve function"

"Physician or therapist required to have direct (one on one) patient contact"

- Applies to all the procedures 97110-97755, 97150 (group)
- Requires direct contact by therapist with two or more patients
- CPT Assistant publication describes "direct (one on one) patient contact, as requiring visual, verbal or manual contact with the patient"

Reporting Therapeutic Procedures
Direct One-On-One Contact

Documentation of Direct Contact Services
- CPT descriptor includes direct (one-on-one) contact: not just a payment policy issue
- Documentation should indicate specific treatment provided in language that can be compared with billing on claim form
- Document area of body, technique used, and outcome of treatment
- Can be provided by PT or properly supervised PTA (Medicare) or by other support personnel per state law and specific payer policy
- Cannot be simultaneously providing direct (one-on-one) contact services to more than one patient at a time

Reporting Therapeutic Procedures
General Guidance

- 5 CPT descriptors describe a type of exercise intervention
- Report Code that best describes outcome to be achieved
- Avoid coding around payment policy
- Documentation must support code reported

Reporting Therapy Services
Minimizing Risk

Audit Red Flags: Coding around policy

- Patient is referred to "ABC Hospital OP Dept." for aquatic therapy
- Patient’s insurance does not include water based exercise as a covered service

Options to avoid coding around payment policy:
1. Patient agrees to pay out of pocket for the aquatic therapy interventions
2. Develop an alternative POC that is appropriate to reach functional goals and consent is provided by patient to proceed
3. Patient addresses policy limitation with their insurer with Therapists assist with patient considering options for treatment as above

Therapeutic Procedures
Coding Therapeutic Exercise

97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength, endurance, range of motion and flexibility

97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception for sitting and/or standing activities

97113 Aquatic therapy with therapeutic exercise

Examples:
- Aqua, therapy
- with therapeutic exercises
- sitting and/or standing activities
- coordination, kinesthetic sense, posture and proprioception
- Neuromuscular reeducation
- therapeutic exercises
- strength, endurance, range of motion and flexibility

Examples:
- phonophoresis
- dry needling
- iontophoresis
- aquatic therapy
- therapy
- exercise

Examples:
- differen,ng between there ex,
- neuro re-ed, therapeutic activities
- if no such specific code exists then report the service using the appropriate unlisted procedure/service code
- Examples: phonophoresis, dry needling
- Avoid coding around payment policy
- Examples: aquatic therapy, iontophoresis

Examples:
- diferen,ng between there ex,
- neuro re-ed, therapeutic activities
- if no such specific code exists then report the service using the appropriate unlisted procedure/service code
- Examples: phonophoresis, dry needling
- Avoid coding around payment policy
- Examples: aquatic therapy, iontophoresis
### Reporting Therapeutic Procedures
#### Manual Therapy

- **97140** Manual therapy techniques (eg; Mobilization/ manipulation, manual traction, manual lymphatic drainage, one or more regions, each 15 minutes
- **97124** Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

**Documentation Hints:**
- Describe technique, area being applied to and indicate the intended functional outcome of intervention
- Massage typically also considered a manual technique

### Reporting Therapeutic Procedures
#### Additional Reporting Issues

- Wrapping techniques utilized as part of lymphedema management is best described as part of manual therapy techniques (97140)
- Taping to address proprioceptive deficits or other movement issues (ie; kinesiotaping) are best described as 97112, neuromuscular re-education
- The tape is considered a supply and not part of CPT code

### Therapeutic Procedures
#### Coding Therapeutic Exercise

- **97530** Therapeutic Activities, direct (one on one), patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
- **97150** Therapeutic Procedure(s), group (2 or more individuals) Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist

### Reporting Therapeutic Procedures
#### Coding Training Interventions

- **97535** Self-care/home management training (eg., Activities of Daily Living, Compensatory training, safety procedures and instructions in use of technology, adaptive equipment) direct one-on-one contact by the provider, each 15 minutes
- **97537** Community/work reintegration training (eg., shopping, transportation, money management, avocational activities, work task analysis, use of assistive technology devices and adaptive equipment), direct one-on-one contact, each 15 minutes

### Resources:

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Therapeutic Procedures  
Reporting Training Interventions

Documentation Hints: 97535 - 97537
- Not typically reported to describe instruction in home exercise program (use 97110, 97112)
- Describe aspects of training, return demonstration and relationship to achieving functional goals
- Document training provided to caregiver if patient is unable to return or if caregiver is necessary to facilitate patients follow-through

Reporting Therapy Services  
Minimizing Risk

Audit Red Flags: Reporting of Timed Codes
- Identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding
- On each date of treatment, document all interventions (timed or untimed) provided regardless of whether or not it is billed
- Document total treatment time in minutes and how much of treatment was performed/described by timed codes
- Recommend: Total treatment time includes the minutes for interventions described by timed codes and untimed codes.
- TREAT, DOCUMENT then CODE

Reporting Therapy Services  
Minimizing Risk

Audit Red Flags: Direct (one on one) Contact
- Intervention must be provided in direct contact with patient, using verbal, manual and/or visual means, and documentation should support that the intervention was provided in this manner
- Example: If 4 patients in pool or gym during one hour of time, therapist could provide 10 minutes of one to one direct contact intervention to each patient, followed by bringing them all together for a group direct contact intervention. Documentation would support both the direct contact one to one service and the direct contact group service in each of the patients treatment notes.

CPT & HCPCS Modifiers  
Coding Challenges and Practice Implications  
Rehabilitation Applications

Modifiers typically used when billing rehab services:
-59 Distinct Procedural Service
-52 Reduced Services
-22 Unusual Procedural Services
-76 Performed twice in one day

Documentation needs to support the Modifier reported with each specific procedure code

CPT Modifiers  
Coding Challenges and Practice Implications  
Rehabilitation Applications

Modifiers allow provider to indicate that a service has been altered by certain circumstances or to indicate that additional information is provided about a procedure performed
- Both CPT and HCPCS Modifiers can be reported on a claim form and are associated with specific CPT codes
- HCPCS Modifiers also assist in identifying information regarding the benefit under which the service is being provided

Diagnosis Coding for Physical Therapy Services ICD-9 and ICD-10
Physical Therapists Reporting Diagnosis
Guidelines for Reporting ICD-9
- Assist in supporting the medical necessity for physical therapy interventions in reflecting a thorough examination, evaluation of findings and development of a plan for care (POC)
- Clinicians should be currently choosing the ICD-9 code(s) that would be consistent with what has been documented in the evaluation that will support the POC
- The primary ICD-9 code should best represent the Medical Necessity for the rehab providers POC

Physical Therapists and Reporting Diagnosis
Reporting ICD-9 “V” codes
- Typically reported on claims from facility-based setting to indicate if rehab was the primary reason for an admission (reference 2005, updated ICD-9 guidelines, for reporting V codes)
- Not always descriptive of medical necessity for POC
- Report another ICD-9 that would represent Medical necessity for POC

Potential Path

Coding Challenges: Diagnosis Coding
Future Initiatives - Transition to ICD-10
- ICD-9 CM have been used in claims process since 1979, has lost accuracy due to not being able to keep up with changes
- New diagnosis code set; ICD-10-PCS, to be implemented October 2014
- Start learning and understanding ICD-10 code set now
- Any alternative payment methods considered for rehab services will be most effective with this transition

Limitations of Current ICD-9 Codes
- Unable to capture all pertinent information related to diagnosis
- Choice of codes was not always optimal or reflective of patient’s condition
- Claims data was difficult to analyze because of the code set limitations
- Decision making for healthcare policies lacked important analytical information
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How is ICD-10 Different?

- Expands code set
- Different structure and organization (7 characters versus 5)
- More detailed
- Updated Terminology consistent with current clinical practice

Physical Therapists and Reporting Diagnosis
Future Initiatives - ICD-10

Structural Differences in Diagnosis Code sets

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 digits</td>
<td>3-7 digits</td>
</tr>
<tr>
<td>First digit is alpha (E or V) or numeric</td>
<td>Digit 1 is alpha</td>
</tr>
<tr>
<td>Digits 2-5 are numeric</td>
<td>Digits 2 and 3 are numeric</td>
</tr>
<tr>
<td>Digits 4-7 are alpha or numeric (alpha digits are not case sensitive)</td>
<td></td>
</tr>
</tbody>
</table>

Practice Implications

- Higher degree of specificity for claims coding – less guessing!
- Ability to capture more specific data that can be related to outcomes
- Ability to monitor practice utilization based on increased specificity of diagnoses
- Documentation will have to capture the same specificity that is reported on claims

General Equivalence Mapping (GEM)

- Tool to assist converting ICD-9 codes to ICD-10 codes
- Translation dictionary
- Forward mapping (ICD-9 → ICD-10)
- Backward mapping (ICD-10 → ICD-9)

- Note: more than one ICD-9 may be a valid translation of a ICD-10 code

Use GEMs When...

- You are translating lists of codes, code tables, or other coded data
- You are converting a system or application containing ICD-9-CM codes
- You are creating a "one-to-one" applied mapping
- You want to study the differences in meaning between the ICD-9-CM classification systems and the ICD-10-CM/PCS classification systems by looking at the GEMs entries for a given code or area of classification

Impact on CPT

- CPT procedure coding will not change because of the implementation to ICD-10.
- Payers will revise payment policies regarding CPT codes that can be billed with specific ICD-10 codes.

TIP: Review all medical payment policies during and after the transition to ICD-10!
CMS Advice for Transition to ICD-10

- Determine which are the most frequently coded conditions in the rehab department and identify pertinent ICD-10 codes
- Begin to learn about the structure, organization, and unique features of ICD-10-CM now!
- Coder training should begin 6-9 months prior to implementation

To Do List

- Educating staff – ongoing
  - What is ICD 10?
  - How will it affect the practice?
  - What needs to be done to prepare?
  - Who is responsible for the transition?

Summary - ICD-10

- Learn about ICD 10 now: download resources, look at payer websites regularly
- http://www.cdc.gov/nchs/icd/icd10cm.htm
- Educate all staff (clinicians and administrative)
- Claim form (5010) already implemented and issues are evident... potential for 6010 with further delays....

Keep Up to Date - ICD-10

https://www.cms.gov/ICD10/02b_Latest_News.asp#TopOfPage

- Sign up for CMS ICD-10 Industry Email Updates
- http://www.cdc.gov/nchs/icd/icd10cm.htm
- Follow topic on Twitter @CMSGov
- Subscribe to Email Notifications to receive a notice whenever CMS ICD-10 “Latest News” page is updated

Preparing Effectively for Outpatient Payment in 2013 & Beyond

Documentation & Medical Necessity

Why is Documentation Such a Big Deal?

- It is the most common mechanism for identifying potentially fraudulent behavior; abuse, and over-utilization, and
- In the end, it will help demonstrate the value of physical therapist practice and our participation as a valid and essential component of the healthcare delivery system.
Medicare Documentation
Setting the Standard
Most, if not all, payers look to Medicare to set the standard for issues relating to:
- Documentation
- Payment
- Fraud and abuse
- Skilled care
- Utilization

Documentation is For
- Ourselves
- Our patients
- Referral sources
- Insurers/Payment
- Legal System
- Professional responsibility
- Provide Evidence to support practice

The Limitations of the SOAP Note Format
- Developed in 1960’s as part of the Problem-oriented medical record (POMR)
- Generally associated with an overly brief and concise style
- Encourages a sequential rather than integrative approach to clinical decision-making
- Lack of emphasis on functional outcomes

Inappropriate Use of the SOAP Note Format
- S: “I have pain”, No new complaints, Pt. better
- O: HP, US, Mass, Ther Ex, HEP
- A: Treatment tolerated well
- P: Continue

Documentation & Medical Necessity
Payer Questions
- Why do PT evaluations only focus on pain, strength, and range of motion?
### Impairment Based Tests and Measures

- Aerobic Capacity/Endurance
- Anthropometric Characteristics
- Arousal, attention, and cognition
- Circulation
- Cranial and peripheral nerve integrity
- Ergonomics and body mechanics
- Gait, locomotion, and balance
- Integumentary integrity
- Joint integrity and mobility
- Motor Function (motor control and motor learning)
- Muscle performance (strength, power, endurance)
- Neuromotor development and sensory integrity
- Pain
- Posture
- Range of Motion
- Reflex integrity
- Sensory integrity
- Ventilation and respiration

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- Reflex integrity
- Sensory integrity
- Ventilation and respiration

### Documentation & Medical Necessity

#### Payer Questions

- The evaluation does not appear to support all of the services provided. What should I look for in an evaluation and in subsequent notes?
- Why is the same information written on every date of service? Shouldn't the treatment change if the patient is making progress?
- What should I look for in the documentation to show that the services provided were skilled?

### Documentation & Medical Necessity

#### Payer Questions

- The notes do not provide information about the patient’s functional status. How can I tell if the patient is improving if all the documentation reports are measurements of ROM, strength, or pain?
- How can I tell how much time is spent with the patient if the therapist does not document time in the notes?
- How long are modalities typically provided?
- What do these abbreviations mean?

### Documentation & Medical Necessity

#### Payer Questions

- I can’t tell from the flow sheets if the patient is making progress toward their goals?
- How can I tell if the interventions listed on the flow sheet are skilled?
- How often should a re-evaluation be done and what should it tell me?
- The patient stopped coming to physical therapy, but the last documentation entry does not indicate that the patient’s problem was resolved. What happened?

### Documentation & Medical Necessity

#### Payer Questions

*Five Primary types of information:*
- What is wrong with the patient?
- Examination/evaluation, diagnosis
- What is planned for the patient?
  - Plan of care, goals, prognosis
  - What skilled interventions are required and what specific services are being provided?
  - Daily notes
- What progress is being made toward discharge?
  - Daily notes, progress reports, re-evaluations
  - What is the final result of the services delivered, patient prognosis, and status at discharge?
  - Discharge summary
Documentation & Medical Necessity
What Are Auditors/Reviewers Looking For?

The Basics:
- Services were actually provided
- Services meet definition of Medical Necessity
- Services were provided by a qualified provider
- Services provided required the skills of a PT or PTA
- Intervention appropriate for diagnosis
- Appropriate frequency and duration
- Expectation of significant functional improvement

Documentation & Medical Necessity
What Are Auditors/Reviewers Looking For?

Need for skilled care evident:
- Level of complexity and sophistication is evident
- Clinical reasoning is demonstrated
- Interventions provided clearly relate to identified impairments which impact functional limitations
- Functional Goals for treatment are identified on evaluation in measurable terms
- Documentation supports the time spent with the patient, and the time spent is justified by the interventions documented

Documentation & Medical Necessity
What Are Auditors/Reviewers Looking For?

Demonstrate progress toward discharge:
- Note changes in impairments and functional limitations
- Any measurement should be recorded and connected to function if possible
- For reevaluations, note reason for reevaluation
- i.e. new clinical findings, lack of progress, need to assess if new clinical services are warranted
- Record any changes made in the POC and any patient/care give instructions or HEP
- Will information effect expected outcomes or timeline?

Documentation & Medical Necessity
What Are Auditors/Reviewers Looking For?

Discharge Summary should include:
- Reason for discharge
- Patient’s functional status at discharge
- Use Criteria for Discharge in the Guide
- Document progress of patient in achieving goals identified in the POC
- Recommendations for future services or follow-up as necessary
- Document any communication with other health care providers

Documentation & Medical Necessity
What Are Auditors/Reviewers Looking For?

Top 5 audit flags in physical therapy documentation:
- Lack of accurate reporting of time in relationship to provision of clinical services
- Lack of support for reported interventions requiring one to one contact
- Lack of progress documented over episode of care
- Use of passive care (including modalities) over majority of episode of care
- Lack of functional context in evaluation, treatment and at discharge
- All lead to a determination of: Lack of Medical Necessity

Is it Medically Necessary Because I Say So?

Who is responsible for determining Medical Necessity?
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Medical Necessity
Definitions and Usage

Model Contractual Language for Medical Necessity
Center for Health Policy, Stanford University

Authority
Purpose
Scope
Evidence

http://healthpolicy.stanford.edu/

Medical Necessity
Definitions and Usage

Medically Necessary Physical Therapy Services

Authority
Purpose
Scope
Evidence
Value

http://www.apta.org/uploadedFiles/APTAorg/
About_Us/Policies/BOD/Practice/
MedicallyNecessaryPTsvcs_BODP08-11-03-04.pd
f

Medical Necessity
Definitions and Usage

Purpose

Physical therapy is provided for the purpose of minimizing or eliminating impairments, activity limitations and/or participation restrictions.

Medical Necessity
Definitions and Usage

Scope:

Physical therapy is delivered throughout the episode of care by the physical therapist or under their direction and supervision, requires the knowledge, clinical judgment and abilities of the therapist, takes into consideration the potential benefits and harms to the patient and is not provided exclusively for the convenience of the patient.

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Medical Necessity: Definitions and Usage

Evidence:
- Physical therapy is provided using evidence of effectiveness and applicable physical therapy standards of practice

Value:
- Physical therapy should be considered medically necessary if the type, amount and duration of services outlined in the plan of care increase the likelihood of meeting the stated goals to improve function, minimize loss of function, and/or decrease risk of injury and disease.

Medical Necessity and Coverage Policies

- Payers embed “medical necessity” language into coverage policies.
- Important to utilize the key words found in the coverage policy within your documentation (plan, goals, and notes) to help effectively communicate the services being reported to the payer.
- Bottom Line: Therapist determines the need for OT/PT services in third party pay environment

Providing for Treatment in an Episode of Care

What is Medical Necessity?

- A thorough and complete evaluation drives the management of the patient and is key to achieving a successful outcome
- Assessment is the ongoing process that keeps the clinician on track
- Payment methodology’s to be driven by outcomes of medically necessary care

CMS: “Medically Necessary”

- Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren’t mainly for the convenience of you or your doctor.

Medical Necessity

Take Home Message....

- Understand a payer's definition of medical necessity as this will have ramifications for:
  - Coverage
  - Payment
  - Documentation needed to support that payer's opinion of what are "medically necessary" services.

97116: Gait Training

**Documentation Example**

| 1) Patient ambulated 50’ x 2 with walker. | Incomplete documentation |
| 2) Patient ambulated 50’ x 2 with walker on smooth surface requiring verbal cueing for weight shifting and step length. Starting HR 72/min. HR after walking 85/min and returned to 72/min after rest. | Complete: measurable, provider work and skilled care |

97116: Gait Training

**Long Term Goal**

| 1) Patient required verbal cueing and contact guarding to ambulate 60 feet in 45 seconds. |

**Documentation**

| 1) Patient can be able to cross the street independently with a standard cane in 45 seconds: 4 weeks. |
| 2) Patient will be able to ascend and descend stairs independently without a railing using a standard cane: 4 weeks |
| 2) Patient required contact guarding and verbal cueing for proper gait sequencing on stairs (no railing) with a standard cane. Patient learns against wall to assist with balance. |

97140: Manual Therapy

**Documentation Example**

| 1) STN x 20’ | Incomplete documentation |
| 2) Soft tissue mbs to left upper trapezius and rhomboids x 10’; trigger points less tender to palpation after mobs; followed by passive stretching and contract/relax techniques to promote ROM C-spine in all planes; following manual therapy flex 50, ext 40, R rot 60, L rot 50. | Complete: Specific muscles groups noted - Palpation and mobs support work of the therapist - Being used as an adjunct to 97110 per Palmetto - ROM measures included |

**Medical Necessity and Medicare FCSO Local Coverage Determination (L29289)**

**Manual Therapy (CPT code 97140)**

- Manual therapy includes the following modalities:
  - Manual traction may be considered reasonable and necessary for cervical radiculopathy.
  - Joint mobilization (peripheral or spinal) may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.
  - Myofascial release/soft tissue mobilization, one or more regions, may be medically necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk. Skilled manual techniques (active or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, or stretching of shortened muscular or connective tissue. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.
  - Manipulation may be medically necessary for treatment of painful spine or restricted motion of soft tissues. It may also be used as an adjunct to other therapeutic procedures such as 97110, 97112, and 97530.

**Gait Training (CPT code 97116)**

- This procedure may be medically necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.
  - Specific indications for gait training include:
    - The patient has suffered a central or peripheral vascular accident resulting in impairment in the ability to ambulate, new instability and ready to begin rehabilitation.
    - The patient has recently suffered a musculo-skeletal trauma, either due to an accident or surgery, requiring ambulation education.
    - The patient has a chronic, progressively debilitating condition for which safe ambulation has recently become a concern.
    - The patient has had an injury or condition that requires instruction in the use of a walker, crutches, or cane.
    - The patient has been fitted with a brace/prosthesis and requires instruction in ambulation; and/or
    - The patient has a condition that requires retrieving in stairs/steps or chair transfer in addition to general ambulation.

- Gait training is considered medically reasonable and necessary when the patient's walking ability is not expected to improve.
  - This procedure is only considered medically necessary when the goal is to increase the patient's strength and endurance.
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So What Is “Skilled Care”?

How Do You Document Skilled Care?
Historical problem with physical therapy documentation:
- Documentation focuses on patient activities versus therapist interaction with the patient
- Flow sheets of exercise indicate repetitive exercise or use of equipment with no indication of skill required by therapist

Relationship Between Practice and Payment

Medicare: The Ultimate “Third Party” Payer

Medicare Coverage
In order for a service to be covered under the Medicare program:
- It must have a benefit category in the statute
  - Therapy services are a benefit under §1861 of the Social Security Act.
- It must not be excluded, and
- It must be reasonable and necessary.
- Medicare Benefit Policy Manual (BPM)
  - [http://www.cms.gov/Manuals/IOM/list.asp](http://www.cms.gov/Manuals/IOM/list.asp)

Skilled Therapy under Medicare
Reasonable and Necessary
To be considered reasonable and necessary (i.e. medically necessary) the following conditions must each be met:
- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition.
- Acceptable practices for therapy services are found in:
  - Medicare Manuals
  - Contractors Local Coverage Determinations
  - Guidelines and literature of the professions of physical therapy, occupational therapy, and speech-language pathology

Medicare Coverage
The following requirements are also conditions of payment:
- Individual “needs” therapy services;
- A plan for furnishing such services has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician/NPP; and
- Services are or were furnished while the individual is or was under the care of a physician; and
- Services must be furnished on an outpatient basis.
Skilled Therapy under Medicare
Defining “Unskilled” Services

Medicare standard for therapy services to be covered:

- Services must be skilled therapy services as defined by Medicare and must be rendered under the conditions specified by Medicare.
- Other third party payers (including Workers’ Compensation) incorporate these concepts into their policies.

Skilled Therapy under Medicare
Defining “Unskilled” Services

Unskilled Services defined as:

- Provided by professionals or personnel who do not meet the qualification standards
- Services by qualified people that are not appropriate to the setting or conditions

Skilled Therapy Under Medicare
Defining “Unskilled” Services

- Unskilled services are palliative procedures that are repetitive or reinforce previously learned skills
- Services which maintain function after a maintenance program has been developed
  - These services are not covered because they do not involve complex and sophisticated therapy procedures, or the judgment and skill of a qualified therapist for safety and effectiveness.

Skilled Therapy Under Medicare
Defining “Unskilled” Services

- Services related to activities for the general good and welfare of patients do not constitute PT/OT services for Medicare purposes (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation).

Skilled Therapy Under Medicare
Defining “Unskilled” Services

- Services not provided under a therapy plan of care, or are provided by staff who are not qualified or appropriately supervised, are not covered or payable therapy services.

Skilled Therapy Under Medicare
Reasonable and Necessary

- Services must be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his/her supervision.
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Skilled Therapy Under Medicare
Reasonable and Necessary

- Services must require the expertise, knowledge, clinical judgment, decision making, and abilities of a therapist that other staff, caretakers or the patient cannot provide independently.
- A therapist’s skill may also be required for safety reasons.
  - Example: an unstable fracture requires the skill of a therapist to do an activity that might otherwise be done independently by the patient at home.

Skilled Therapy Under Medicare
Reasonable and Necessary

- Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- A service that ordinarily would be performed by non-skilled personnel could be considered a skilled PT/OT service where there is clear documentation that, because of special medical complications, a qualified PT or OT is required to perform or supervise the service.

Skilled Therapy under Medicare
Reasonable and Necessary

Skill may be documented by:
- The clinician’s descriptions of their skilled treatment,
- The changes made to the treatment due to a clinician’s assessment of the patient’s needs on a particular treatment day, or
- Changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.

Documenting Functional Performance
A Skill-Based Model

Skill can be defined as the ability to achieve a desired outcome with consistency, flexibility, and efficiency:
- Consistency: Ability to successfully perform a skill repeatedly over multiple trials or days
- Flexibility: Ability to perform a skill under a variety of environmental conditions
- Efficiency: Ability to perform a skill within a certain level of energy expenditure (cardiovascular and musculoskeletal).
**Documenting Functional Performance: A Skill-Based Model**

**Consistency:** Ability to successfully perform a skill repeatedly over multiple trials or days
- Rate of goal achievement (# of successes/# of attempts)
- Number of days/week able to perform
- Accuracy (spatial measures of errors)
- Accuracy (# of errors)

**Documentation Example:**
- Patient is able to ambulate 300 ft using standard cane, with occasional verbal cues for sequencing, on level surface, three consecutive trials with a 2 minute rest period between trials.

**Documenting Functional Performance: A Skill-Based Model**

**Flexibility:** Ability to perform a skill under a variety of environmental conditions
- Height, surface, position of equipment
- Environment (e.g., open vs. closed)
- Ability to do two tasks at once

**Documentation Example:**
- Patient safely able to climb up 6 steps of 8", w/ railing (ft of steps in home); unable to carry anything in hands with this activity. Requires verbal reminders for foot placement to safely climb up 4, 10" steps (outside step at home) with railing.

**Efficiency:** Ability to perform a skill within a certain level of energy expenditure (cardiovascular and musculoskeletal).
- Time to complete task
- Distance completed
- Speed of Movement
- Heart Rate, respiratory rate, or blood pressure changes

**Documentation Example:**
- Patient can walk distance of 10ft. (from bed into bathroom) in 14.2 seconds (average time/3 trials) with increased HR to 100 bpm.

**Documentation & Medical Necessity How Do You Document Skilled Care?**

- Including in your documentation the answer to one or more of the following questions will help demonstrate the skills involved with the interventions documented:
  - What are the clinical skills or judgment being used for this intervention?
  - What is the complexity and sophistication of a particular intervention that requires the skills of a PT or appropriately supervised PTA?
  - Could this intervention be delivered without the skills of the PT or appropriately supervised PTA?
  - What are the associated risks that require the skills of the PT or supervised PTA?
  - What specific instructions, assistance, or safety procedures require the skills of the PT or PTA?
Documentation & Medical Necessity

How Do You Document Skilled Care?

Documenting therapist interaction (skill):

- Verbal and manual cuing to facilitate appropriate muscle recruitment during core stabilization exercise
- Proprioceptive training to facilitate optimal head, neck, thorax, scapulae, and upper extremity alignment and movement sequencing
- Monitoring of cardiovascular vital signs to ensure safe exercise tolerance levels.

Medical Necessity & the Therapy CAP

- Use of the KX modifier shall be interpreted as the therapist’s attestation that services provided above the cap are medically necessary.
- The exception is granted on the clinician’s assertion that there is documentation in the record justifying that the services meet the criteria for reasonable and necessary services.

Functional Outcome Reporting

The Focus of Physical Therapy Documentation

Key Pitfall: Medical Necessity not established in Documentation

- Reason for referral not clearly established
- Examination heavily impairment based without comparative or objective measures
- Activity limitations not identified in objective and measurable terms
- Goals developed based on impairments with no functional context or goals stated do not relate to any described activity limitations

Managing your Patient

Communicating effectively in the Medical Record

Points of Discussion

- Elements of treatment: Communication of Medical Necessity and Skilled care
- Reporting Progress: Considering impairments in a functional context, revisiting goals
- Documentation reflecting direct contact, patient/therapist interactions
- Effective communication of Home instruction and Outcomes

Documenting of Medical Necessity

Progress Towards Discharge of Episode of Care

Communicating Progress Includes:

- Objective measures of both impairments and function
- Document in context of Discharge Goals, if not on track, adjustments made and documented
- Update all home instruction and document patients/caretakers understanding and compliance
- Demonstrate the continued value for continuing with participation in POC
Evaluation

Functional Documentation Checklist

Evaluations Should Include:
- Reason for referral (what affects patients function)
- Diagnosis PT/OT is treating
- Past level of function
- Current level of function, with objective measures
- Documentation of potential for return of function (cognitive/physical)
- Plan of Care (POC) that will impact functional goals

Establishing a Reason for Referral

Subjective Information/Current Condition

- Typical Documentation Statement:
  - Patient reports pain

- What is Wrong:
  - Type of pain and location is not described in detail

- Appropriate Documentation:
  - Patient reports pain in central low back, radiating into left buttock, which began 2 weeks ago
  - Patient reports pain level of 4/10 at rest, increasing to 7/10 with prolonged standing (>10 minutes)

IE: Establishing An Objective Baseline

Documenting Functional Status

- Typical Documentation Statement:
  - Patient c/o pain with standing

- What is Wrong:
  - Focus should be on standing (a function) not on pain (an impairment)

- Appropriate Documentation:
  - Pt. is able to stand for max. of 15 minutes.
  - After this, pt. reports gradual increase in LBP (4/10 on VAS) – needs to sit after 23 minutes

Establishing a Reason for Referral

Subjective Information/Current Condition

- Typical Documentation Statement:
  - Patient unable to perform ADLs

- What is Wrong:
  - Specific ADLs not describes

- Appropriate Documentation:
  - Patient unable to reach behind to fasten bra due to shoulder pain/limited range of motion
  - Patient unable to prepare dinner due to inability to stand > 2 minutes without pain and UE weakness limiting food preparation

Establishing a Reason for Referral

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- Current level of function, with objective measures
- Documentation of potential for return of function (cognitive/physical)
- PLAN OF CARE that will impact functional goals

Typical Documentation Statement:
- Patient reports pain

What is Wrong:
- Type of pain and location is not described in detail
- Does not provide meaningful information about pathologic condition

Appropriate Documentation:
- Patient reports pain in central low back, radiating into left buttock, which began 2 weeks ago
- Patient reports pain level of 4/10 at rest, increasing to 7/10 with prolonged standing (>10 minutes)
IE: Establishing An Objective Baseline
Documenting Functional Status

- **Typical Documentation Statement:**
  - Sitting balance poor
- **What is Wrong:**
  - Not measurable, “poor” is vague terminology
  - Better to describe sitting ability in a specific context
- **Appropriate Documentation:**
  - Patient is able to sit for 10 seconds unsupported on mat table, feet flat on floor, before losing balance to right side
  - Needs assistance to return to an upright sitting position

---

IE: Establishing An Objective Baseline
Documenting Functional Status

- **Typical Documentation Statement:**
  - Able to ambulate 50 feet
- **What is Wrong:**
  - Context not specified; not enough detail
  - Describe where patient can walk, such as surface conditions or specific environment
  - Should indicate level of assistance and assistive devices
- **Appropriate Documentation:**
  - Patient can walk a maximum of 50 ft. on carpeted surface, using straight cane
  - Limited due to fatigue; HR increased from 78 resting to 118

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IE: Establishing An Objective Baseline
Documenting Functional Status

- **Typical Documentation Statement:**
  - Able to climb a few stairs with complaint of fatigue
- **What is Wrong:**
  - Not enough detail; provide more details on capability
  - A “few” is not measurable; indicate # of stairs, pattern of stair climbing, speed, cardio vascular changes
- **Appropriate Documentation:**
  - Patient can ascend/descend 8 stairs, step over step, with one hand on right railing
  - HR increases from 64 resting to 136

---

IE: Establishing An Objective Baseline
Documenting Functional Status

- **Typical Documentation Statement:**
  - Patient able to move much better than before
- **What is Wrong:**
  - “Much better” not measurable; specify degree of difficulty or ability
  - Which components of movement are being referred to (i.e. walking, climbing, transitioning from sitting)
- **Appropriate Documentation:**
  - Patient able to transition from standing to crawling position without unweighting right lower extremity and maintaining safe low back posture while crawling 30 feet

---

Functional Outcome Reporting

How do I put this all together?

- **Focuses on documenting** the ability to perform meaningful functional activities rather than impairments
- Establishes the **rationale** for therapy by indicating the link between impairments and the disability they cause the patient
- Promotes a style of **clinical decision making** that begins with functional problems and assesses the specific impairments that cause the functional limitations.
## Functional Outcome Reporting
Organize flow of evaluation process:
- Reason for referral
- Relevant medical history
- Functional status: previous, current and potential for return
- Measure impairment, activity restrictions, and outcomes
- Describe goals from functional perspective
- Plan for achieving outcomes of return to function

## Predicting a Functional Outcome
### Functional Outcome Goals
Physical Therapist’s Responsibility:
- **To predict the functional outcome of your treatment**

If we are uncomfortable with this process, consider this:
- If as physical therapists we do not know what the effect of our treatment is, then who does?
- Why should our patients expose themselves to our treatment if we don’t know, can’t explain, or don’t document what the outcome of a skilled treatment program should be?

## Devising a Treatment Strategy
### Plan of Care with Rationale
- Plan of Care is a *prediction* of what will best impact the impairment and functional limitation based on clinical reasoning
- Plan of Care is documented to provide information to both the patient and the payer about how therapy interventions will directly alter the patient’s physical status (impairments) and functional limitations
- Includes, at a minimum:
  - Diagnosis for which therapy is being provided
  - Goals for the Episode of Care
  - Planned Interventions to achieve goals (with parameters)
  - Anticipated Frequency and Duration

## Predicting a Functional Outcome
### Functional Outcome Goals
Considerations: Short Term/Long Term Goal development
- What is “Long Term” in today’s health care system?
- We have added attempts to use measurable goals but rationale for particular measure is generally not identified by therapist:
  - e.g. “Increase shoulder strength to 5/5”
  - e.g. “180 degrees of shoulder flexion”
- The effect, consequence, or outcome physical therapy will have in addressing the impairment or functional limitation is generally not considered, or if it is, is not documented.
- Goals are often never referred to again in the record after IE
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Predicting a Functional Outcome
Developing Functional Outcome Goals

- You can’t establish a measurable functional goal for an episode of care for something you have not measured or established a baseline to begin with!
- Focus on Function: Activity Limitations and Participation Restrictions
- Measure Baseline Activity Limitations
- Utilize International Classification of Function (ICF) to promote documentation of disability progression using standard criteria
  - http://www.who.int/classifications/icf/en/

Disability Progression (Based on ICF):
- No disability 96-100% of normal
- Mild disability 76-95% of normal
- Moderate disability 51-75% of normal
- Severe disability 5-50% of normal
- Total disability 0-4% of normal

Predicting a Functional Outcome
Developing Functional Outcome Goals

Disability Progression: Deskwork Capacity
Example of a patient case scenario: Low Back Pain

- No difficulty: deskwork capacity unlimited
- Mild difficulty: able to work at desk 4-8hrs/day
- Moderate difficulty: able to work at desk 1-4 hrs/day
- Severe difficulty: able to work at desk < 1 hour/day
- Complete difficulty: impairments prevent deskwork

Predicting a Functional Outcome
Developing Functional Outcome Goals

Disability Progression: Deskwork Capacity
Example of a patient case scenario: Low Back Pain

- Connect...the...Dots....
  - Reduced Impairments...leading to.....
  - Increased Activity Performance...resulting in....
  - Enhanced Participation Abilities

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Functional Outcomes
Developing Functional Outcome Goals

- Examination procedures should determine relevant functional limitations and identify the impairments causing those limitations
- Impairments should be identified as they relate to the functional activities
- Goals of therapy should be explicitly defined in terms of the functional activities that the patient will be able to perform
- Specific interventions should be justified in terms of their effects on functional outcomes
- The success of intervention should be measured by the degree to which desired functional outcomes are achieved

Predicting a Functional Outcome
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Predicting a Functional Outcome
Developing Functional Outcome Goals

Disability Progression: Deskwork Capacity
Example of a patient case scenario: Low Back Pain

- Connect...the...Dots....
  - Reduced Impairments...leading to.....
  - Increased Activity Performance...resulting in....
  - Enhanced Participation Abilities

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Target Timeframe/Date
- 2 weeks, 6 weeks, 5 visits, 10 visits
Predicting a Functional Outcome
Functional Outcome Goals: Examples
Area of Body; Impairment; Impairment Goal; Functional Activity; Target Performance; Rationale; Target Timeframe/Date

- The patient’s bilateral upper extremity strength will increase to at least 4-/5 to allow her to reach for items in kitchen cabinets repeatedly to facilitate independent preparation of meals; 3 weeks

- The patient’s right shoulder flexion active ROM will increase to at least 135 degrees to allow improved ability to reach items in closet to dress independently; 4 weeks

- The patient’s hip extensor strength will increase to 4/5 to allow independent transfers with improved control to avoid potential fall and further injury; 3 weeks

- The patient’s low back pain level will reduce to 2/10 to enable her to sleep uninterrupted for 6 hours; 4 visits

- The patient’s right upper extremity strength will increase to at least 5-/5 to allow her to reach for, lift and carry 25# to safely carry child; 6 weeks
Predicted Functional Outcome Goals

<table>
<thead>
<tr>
<th>Activity</th>
<th>Target Performance</th>
<th>Rationale</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining a sitting position</td>
<td>Pain free 45 Min</td>
<td>To allow for community transportation/driving</td>
<td>5 Visits</td>
</tr>
<tr>
<td>Maintaining a lying position</td>
<td>&lt; 2/10 pain for up to 6 hrs</td>
<td>To allow for restful sleep</td>
<td>7 Visits</td>
</tr>
<tr>
<td>Climbing stairs</td>
<td>20 stairs pain free</td>
<td>To allow for independent household ambulation</td>
<td>8 Visits</td>
</tr>
<tr>
<td>Walking short and long distances</td>
<td>1 hour pain free</td>
<td>To allow for household and community ambulation</td>
<td>12 visits</td>
</tr>
<tr>
<td>Carrying in the Arms</td>
<td>25 #</td>
<td>To allow for safe carry of 3 year old daughter</td>
<td>14 Visits</td>
</tr>
</tbody>
</table>

Electronic Medical Records

Common Audit Flags in Existing Electronic Documentation Systems
- Non-specific examination findings
- Objective data populated relates to impairments only, without objective functional measures
- Goals not specific, functional, or related to findings on examination
- Evaluation notes reduced to one page, without necessary information to justify medical necessity

Electronic Medical Records

Common Audit Flags
- Canned and generalized “assessment” statements
- Signature area for MD on Medicare POC on separate page than POC required elements
- Electronic programs may require that fields be populated, yet information is:
  - Repeated
  - Not necessary
  - Not relevant, or
  - Does not make clinical sense

Electronic Medical Records

Common Audit Flags
- Standardized notes – no change in elements/content for several visits
- Focus of documented interventions, in pull down menu’s is on activities patient is performing, not what therapist is doing to justify need for skilled care
- Plan of Care does not change, or is general, without specific detail necessary to drive interventions
- Discharge notes do not summarize treatment, progress, or provide for recommendations for follow up
Preparing Effectively for Outpatient Payment in 2013 & Beyond

Learning From Documentation Requirements Under the Medicare Program

Medicare Documentation Requirements
Key Third Party Applications

Documentation of Date of Services
- May be in any form (written, stamped, or electronic).
- The date may be added to the record in any manner at any time, as long as the dates are accurate.
- If services provided on one date are documented on another date, both dates should be documented.
- Electronic signatures are allowed if protected, otherwise must be written, no stamped signatures are allowed.

Types of documentation which are expected to be submitted in response to any request for documentation:

- Evaluation and Plan of Care (1 or 2 documents)
- Progress Reports (when records are requested after the reports are due).
- Treatment Notes for each treatment day (may also serve as progress reports when required information is included in the notes)
- Discharge Summary (if applicable)
- Documentation from other providers involved with care of patient

Evaluation and Plan of Care
- A clinician may include objective measures made by the PTA/COTA within their scope of work, but the clinician must actively and personally participate in the evaluation or re-evaluation.
- Plan of care can be developed for up to 90 day duration from the date of the evaluation
- Be aware of state law as it pertains to PTA supervision

Plan of Care: Contents
- The Plan of Care shall contain, at a minimum, the following information as required by regulation:
  - Diagnoses;
  - Long Term treatment goals; and
  - Type, amount, frequency, and duration of therapy services.
**Medicare Documentation Requirements**

**Key Third Party Applications**

**Plan of Care**
- Long term treatment goals should be developed for the **entire episode of care** and not only for the services provided under a plan for one interval of care.
- Expectation for a different POC for each discipline, and each must establish a diagnosis, goals, etc.
- A PT may not provide services under an OT POC (and vice versa).

**Certification of the POC**
- Duration up to 90 days
  - Except in the rehab agency setting (30 day)
  - Signature of the physician or other qualified non-physician provider required at 30 days from the IE
  - Provisions for delayed signatures with documentation of reason for delay

**Progress Reports**
- If each element required in a Progress Report is included at least once during the interval in the encounter notes, then a separate Progress Report is not required.
- Evidence of documented progress towards goals or lack of progress every 10 treatment day or by the 30th day in the episode of care

**Treatment Note**
- The purpose of these notes is to:
  - Create a record of all treatment and skilled interventions that are provided.
  - Record the time of the services in order to justify the use of billing codes on the claims.
  - Documentation is required for every treatment day, and every therapy service.
  - The treatment note is not required to document the medical necessity or appropriateness of the ongoing therapy service.

**Progress Reports and Assistive Personnel**
- Physical therapist assistants (as well as COTAs, as appropriate) 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.

**Evidence of documented progress towards goals or lack of progress every 10 treatment day or by the 30th day in the episode of care**
Medicare Documentation Requirements
Key Third Party Applications

Treatment Note (Required Elements):
- Total treatment time in minutes and amount of time provided in “direct contact” with patient.
- Total treatment time includes the minutes for timed code treatment and untimed code treatment.
- The amount of time for each specific intervention/modality provided to the patient may also be recorded voluntarily, but payers typically do not require it.

Medicare Documentation Requirements
Key Third Party Applications

Treatment Note (Required Elements):
- Frequency and intensity of treatment and other details may be included in the plan of care and need not be repeated in the treatment encounter notes unless they are changed from the plan; and

Medicare Documentation Requirements
Key Third Party Applications

Treatment Note (Required Elements):
- 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.
- The signature of the supervisor (PT/OT) 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 POC or Progress Report.

Medicare Documentation Requirements
Key Third Party Applications

Treatment Note
- Documentation of each treatment encounter should also include the following optional elements to be mentioned only if the therapist or therapist assistant recording the note determines they are appropriate and relevant.
- If these are not recorded daily, any relevant information should be included in the Progress Report:

Medicare Documentation Requirements
Key Third Party Applications

Discharge Note
- Is required for each episode of treatment
- DC note shall be a Progress Report written by a clinician, and shall cover the reporting period from the last Progress Report to the date of discharge.
- In the case of an unanticipated discharge, the clinician may base any judgments required to write the report on the Treatment Notes and the verbal report of the assistant.
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Florida Physical Therapy Association
9/13/12

Medicare Documentation Requirements

Key Third Party Applications

Discharge Note
- May choose to summarize entire episode of treatment
- Should justify services that may have extended beyond those usually expected for the patient’s condition
- Consider the DC note to be the last opportunity to justify the medical necessity of the entire treatment episode in case the record is reviewed.

Discharging an Episode of Care

Professional Considerations

- Updating nomenclature to reflect best practice
- Evaluation process includes planning the discharge process
- Your documentation at the end of the episode is an opportunity for clarity and closure
- Opportunity for reporting services that are part of Discharge process can exist

Discharging an Episode of Care

Medicare Requirements

- Documentation describing the patient’s functional status at discharge is required for each episode of treatment
- Discharge documentation shall be written by Clinician and describe progress achieved from the last required progress report period to date that POC is being discharged
- In the case of an unanticipated discharge, the clinician may base any judgments required to write the DC report on treatment notes from last visit and the verbal report of others qualified to be involved in care (PTA, COTA)

Discharging an Episode of Care

Start at the Beginning

Critical to have a complete process, starting at the evaluation and ending at discharge of the episode of care
- Establish the rationale for therapy by indicating the link between impairments and the disability they cause the patient
- Focuses on documenting the ability to perform meaningful functional activities rather than impairments
- Promotes a style of clinical decision making that begins with functional problems and assesses the specific impairments that cause the functional limitations and describes the anticipated outcomes and documents the result at discharge

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Discharging and Episode of Care
Key Elements for Defining Outcomes of Care

- Outcomes:
  - Any tools used to describe the patients functional status need to be reported at the start of care, at the interim and at the end of care.
  - Need to be reported and related to the patients progress through the plan.
  - Outcomes reporting if done routinely at beginning and at end of care, can be used to measure effectiveness of your practice and clinicians efforts.
  - Can provide an opportunity for continued interaction with patient as a client in programs related to maintaining or enhancing function.

Discharging and Episode of Care
Key Elements for Assuring Continued Impact

- Patient/Family/Caregiver Instruction
  - Any tools used to train, educate the patient, family member or caregiver in their conditions, functional loss or related modifications, at the outset of the POC need to be well described, dated and part of the medical record.
  - These tools (HEP’s, Self Care Instruction) Need to be updated as POC progresses and updates should be part of the Medical Record.
  - At or near DC, these tools need to be updated for patients and others, in order to assure continued benefit of care.

Discharging an Episode of Care
Reporting the Discharge Visit

Elements of a Discharge Visit:
- Instruction leading to establishment of compensatory skills;
- Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system);
- Patient and family training to augment rehabilitative treatment or establish a maintenance program.

Discharging an Episode of Care
Reporting the Discharge Visit

Evaluation and Discharge on same DOS:
- Initial evaluation of the extent of the disorder, illness, or injury, and treating qualified professional determines the potential for rehabilitation is insignificant.
- An appropriate maintenance program may be established prior to discharge.
- Since the skills of a therapist are required for the development of the maintenance program and training the patient or caregivers, this service is covered.

Discharging an Episode of Care
Reporting the Discharge Visit

Example: Patient with DX of Parkinson’s Disease, is close to discharge from a PT POC, may require the services of a therapist during the last week or two of treatment or on day of DC, to determine type of exercises that will contribute effectively to maintain the patient’s present functional level following cessation of treatment.
- The design of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist.
- The instruction of the patient or family members in carrying out the program, and
- such infrequent reevaluations as may be required would constitute covered therapy because of the need for the skills of a qualified professional.

Discharging an Episode of Care
Reporting the Discharge Visit

Maintenance programs:
- The goals would be, for example, to maintain functional status or to prevent decline in function.
- Services are covered when documentation reflects the specialized skill, knowledge and judgment of a therapist, to
  - design or establish the plan,
  - assure patient safety,
  - train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.
Discharging an Episode of Care

**Reporting the Discharge Visit**

*Example:* PTA performing DC visit:
- In the case of a discharge anticipated within 3 treatment days of the Progress Report, the clinician may provide objective goals which, when met, will authorize the assistant to discharge the patient.
- The clinician should verify that the services provided prior to discharge continued to require the skills of a therapist, and services were provided or supervised by a clinician.
- Discharge note shall include discussion of treatment provided since the last progress report and indicate that the therapist reviewed the notes and agrees to the discharge.

**Discharging an Episode of Care**

**Key Metrics to Review**

- **Progress Report Period**:
  - Outcome tools repeated at interim point in plan of care
  - % Functional Change reported on claim forms
  - Progress described with objective measures and updates on stated functional goals
  - RAC/Cert Audits re; continued Medical Necessity for POC
  - Updated Plan of Care complete and re-certification if needed
  - Upon review, Technical denial with no appeals

- **Evaluation Process**:
  - Initial outcomes tool complete and documented
  - % Functional Change reported on claim forms
  - Objective measures of impairments/functional loss linked to functional goals
  - RAC/Cert Audits re; Medical Necessity for POC
  - Plan of care complete and certified
  - Upon review, Technical denial with no appeals

- **Treatment**:
  - Time is documented to support billed charges
  - RAC/CERT/ZPIC Audits for time based procedures
  - Clinical notes reflect skills required of PT/OT, assistive qualified personnel and direct contact nature of service
  - CPT codes reported appropriately and care continues to be medically necessary

- **Discharging an Episode of Care**

**Key Metrics to Review**

- **97002 Physical Therapy Reevaluation**
- **97004 Occupational Therapy Reevaluation**

Reporting a re-evaluation at the DC visit would be defensible if documentation does the following:
- Reflects tests/measures performed at this visit to demonstrate impairment/functional change and remaining deficits
- Recommendations are clearly related to management of remaining functional deficits with information as to follow-up required by patient and communication with other professionals that may be referred to.
Discharging an Episode of Care

Key Metrics to Review

- Discharge of Episode of Care
- Outcome tools repeated at discharge of plan of care
- % Functional Change reported on claim forms, % goals reached
- Objective measures and updates on status of stated functional goals
- Medical Necessity for POC, LOS and average number of visits
- Patient Satisfaction captured either through clinician interview or survey
- Commercial plans bonus payments for this metric, marketing stats

Discharging an Episode of Care

Can be a great reflection of a thoughtful, complete and successful Rehab course of care...

Program Resources

References and Resources

- CMS Coverage Center: https://www.cms.gov/center/coverage.asp
- Idaho Medicare Administrative Contractor (MAC) http://www.noridianmedicare.com

References and Resources

- Medicare Manuals: http://www.cms.gov/Manuals/IOM/

Resources

Documentation

- CMS Documentation Requirements
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Resources
Documentation
- Federation of State Boards of Physical Therapy
  - http://www.fspt.org
- AOTA
  - http://AOTA.org
- APTA Claims Review Guidelines
- The Guide to Physical Therapist Practice,
  (revised edition on Website TBA)
- APTA’s Defensible Documentation
- APTA’s Hooked on Evidence
  - http://www.apta.org/EvidenceResearch/
- APTA’s Open Door
  - www.apta.org/OpenDoor

Resources
Compliance
- Office of Inspector General
  - http://oig.gov/
- Medicare Appeals
    Downloads/AppealsprocessflowchartAB.pdf
- Industry Resources/FAQ’s on selected topics
  - www.FearonLevine.com

Resources
ABN
- General information regarding Beneficiary Notices
  - https://www.cms.gov/bni/
- Claims Processing Manual- Chapter 1, Section 60.4.1
  - www.cms.gov/manuals/downloads/clm104c01.pdf
- ABN Specific to Fee For Service
  - https://www.cms.gov/BNI/02_ABN.as
- FearonLevine.com
    searchtext=Advanced%20Beneficairy%20Notices

Resources on Documentation Guidelines
For information regarding documentation guidelines for rehabilitation services from the Medicare Perspective
- Benefit Policy Manual
  - Chapter 15, sections 220-230

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- FearonLevine.com
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  - Premier Subscription: $299/year
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  - Use Promo Code: FPTAFLCP
- Or sign up as a free member and receive our monthly compliance newsletter and blast updates!