Medicare Outpatient Documentation: Clearing Up the Myths

MPTA Spring Meeting
April 2017

Lecture Objectives

• Clear up the many myths of Medicare Outpatient Documentation and Billing
• Participants to have full understanding of all components of the Medicare Plan of Care
• Provide list of approved Medicare referral sources to outpatient physical therapy
• Discuss Functional Limitation Reporting in relation to Medicare documentation

References

• Medicare Benefit Policy, Chapter 15 Section 220-223
• Medicare Claims Manual, Chapter 5
• WPS “New to Medicare Teleconference- Medical Review and Documentation” March 7, 2017
• Real life experience!

Does this lecture apply to you?

• Yes if you treat outpatients
  • Private Practices
  • PTPP (Physical Therapist in Private Practice)
  • CFSF (Comprehensive Outpatient Rehabilitation Facility)
  • Hospital based
  • Outpatients of other entities (SNF, Home Health, Rehab Hospital)

Don’t forget these guys too...

• Medicare Advantage plans
• Tricare
• Federal BCBS
• Champus

Presenters

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**Some of this information is from Robbie Leonard, PT lecture at 2016 PPS Conference.**
Myth #1: PTAs can treat independently in my private practice
- Medicare only recognizes the following as qualified professionals for providing PT
  - PTs
  - PTAs under proper supervision
  - MDs and NPPs
- Aides, tech, and athletic trainers cannot bill services to Medicare

Myth #2: PT/PTA students can’t treat Medicare patients
- Students can perform treatment on patients with PT/PTA present
- The care must be one on one with PT/PTA directing the care.

Myth #3: I can’t treat the patient without a signed Plan of Care
- “It is not intended that needed therapy be stopped or denied when certification is delayed.”
- 30-60 days after start of POC-no justification needed
- 60-90 days after start of POC-Need evidence that you are attempting to get POC signed

Myth #4: Plan of Cares are always good for 90 days
- Good for up to 90 days
- Need to set for amount of time therapist realistically expects to see the patient (mild ankle sprain vs. post surgical total knee)
- What if POC isn’t dated?
  - You can write received on XX date when POC is returned or...
  - If POC is faxed, the fax date is sufficient.
Myth #5: A chiropractor can sign a POC

- Chiropractors and Dentists can NOT sign POC if TMJ patient have patient’s PCP sign POC (if they are willing)
- Physicians certified to sign POC
  - MD
  - DO
  - Podiatrists (for feet only)
  - Ophthalmologists or optometrists (for low vision patients only)
  - Physician Assistant
  - Nurse Practitioner

Myth #6: I must have Short Term Goals on the POC

- POC requirement is for LONG term goals only
- However if long term patient (8-12 weeks) short term goals are prudent to assist in showing progress
- If goals are added or changed, POC should be re-sent for certification

Myth #7: I can bill Medicare every 30 days for doing a re-evaluation note

- A re-eval charge is ONLY billable when the patient is not following POC (for better or worse) and the POC needs to be modified OR if patient has significant change in their medical condition requiring new POC.
- No calendar time limit is set that triggers progress note
- Progress note to be done by PT every 10th visit (can do earlier if needed) but does not mean you can bill a re-eval.

Myth #8: Stamped signatures work for POC

- Only handwritten or electronic signature is accepted.
- If handwritten signature is not legible you can print name under signature.
- Stamped signature only permitted in case of physician or other provider having a physical disability who can provide proof of inability to sign.

Myth #9: If a patient self discharges I don’t need to do a discharge note

- Incorrect, discharge note is always required. Here is list of required documentation:
  - Eval
  - Signed POC (or POCs)
  - Progress report every 10th visit
  - Treatment note for every day
  - Justification statement if patient goes over cap.
  - Discharge note

Myth #10: My goals only need to be addressed at time of progress note

- Any changes made to goals, or deletion of goals need to be addressed in daily notes.
- If deleting goal need to state why goal is being deleted.
Myth #11: **I can discharge a patient once they have met the Medicare cap**

- Not if patient has medical necessity.
- Cap in 2017 is $1980 for PT and SLP services combined
- OT has their own cap, $1980
- “Hard” Cap at $3700 – claims are not automatically denied but documentation must demonstrate medical necessity for post-payment review

Myth #12: **Medicare will always pay for therapy once the Medicare cap is hit**

- Not necessarily, must document medical necessity in your patient’s medical record.
- KX modifier needs to be added to claims – this supports services are “medically necessary”
- Threshold limit for 2017 is $3700 for PT and SLP combined, OT once again has its own cap.
- Going above the threshold limit does not necessarily trigger Medicare audit.
- ABN is not appropriate to justify services beyond the cap

Myth #13: **I need to address PQRS in my progress notes**

- No, PQRS program ended 12/31/16.
- Some billing/coding experts recommend continuing for smoother transition to MIPS
- What needs to be in progress note (10th visit or earlier)?
  - Assessment of improvement
  - Extent of progress towards each goal
  - Delete goals that no longer apply
  - Changes to any goals
  - Plan for continuing treatment
  - Justification for skilled care & continuing care
  - Functional limitation reporting

Myth #14: **FLR codes can only be done on visit 10**

- No, FLR can be reported on or before the 10th visit.
- Eval is visit 1
- If you report at visit 8 then next deadline to report will be visit 18

Myth #15: **I can report on more than one G code category at a time**

- No, only one set of G codes can be reported at a time.
- When patient is finished w/ one category you need to discharge that category on that date of service and report NEW category on next date of service.
- Depending on your EMR this will affect ability to be paid on Medicare claims.
- G codes can only be submitted with other procedure codes – if a patient self-discharges, then comes back for later that year for something different, you must first discharge the old codes at the eval, then report the new codes at the 2nd visit

Myth #16: **I can use clinical judgment only when determining FLR impairment percentage**

- No, use of standardize outcome tool is required; however clinical judgement used as well.
- You are required to document the specifics of your FLR category and score and how you made determination of that score.
- FLR goal percentage can change as patient improves or declines. Report new FLR code and justify in your documentation.
- FLR goal should be addressed in LTG’s/POC.
Myth #17: I only have to worry about having Medicare specific documentation if Medicare is primary payer
• False
• FLR codes, POC, etc. all must be done if Medicare is a payer of any sort for patient’s claims.
• Medicare can be the secondary policy to commercial/private insurance in some cases

Myth #18: I can bill the patient for services that Medicare denies
• Not usually
• Not unless you had Medicare patient sign ABN (Advanced Beneficiary Notice of non-coverage) form
• However, routine use of ABNs is not allowed.
• If ABN is on file, then modifier is required on your claims.

Myth #19: I can have a Medicare patient pay cash if they want and NOT bill Medicare
• Not usually
• If a patient has therapy needs that are medically necessary, then you are obligated to provide those and bill Medicare
• You can have a patient pay for services if they are not medically necessary as long as patient has been notified in writing prior to starting care.
• ABN is signed and appropriate GA modifier added to claims to denote that services are not medically necessary and therefore not reimbursable

Myth #20: I can not treat 2 Medicare patients in the gym at the same time
• Wrong, but you must do appropriate billing.
• Can only bill timed codes during one on one time with each patient.
• If you supervise both at the same time, you would bill group.
• To bill “group therapy” participants must be performing the same skilled interventions

Myth #21: I can have the patient pay for supplies used in the clinic, like stim electrodes
• Wrong
• You can have patient pay for supplies that are purchased to use at home, but supplies needed as part of treatment in clinic are not allowed to be billed to the patient.

Myth #22: Medicare Contractors review documentation when claims are submitted to determine if payable
• Pre Payment Review – automated through NCCI edits (gait training and their act on same date), max number of units on a given date
• Post Payment Review – more complex, based on problem areas identified through data analysis
• Your documentation should support the need for medically necessary skilled services during a post payment review
• ADR Letter – request for Additional Documentation Request
Myth #23: **Only Progress Notes/10th visits need to include objective data**

- Use objective and measurable terms (ROM, MMT, pain scale, weights used, distance walked)
- Documentation should be based on facts in addition to observation
- Avoid these terms without objective data to support: “doing well,” “improving,” “less pain,” “increased strength/ROM,” “tolerated treatment well,” “required assistance.”

**Resources**

- CMS Therapy Services Website: [www.cms.gov/therapyservices](http://www.cms.gov/therapyservices)
- APTA, Payment reform, and advocacy resources: [http://www.apta.org/uploadedFiles/APTAorg/Payment/APS/APSQA.pdf?search=%22Payment%20Reform%22](http://www.apta.org/uploadedFiles/APTAorg/Payment/APS/APSQA.pdf?search=%22Payment%20Reform%22)
- CMS ABN Form: [https://www.cms.gov/Medicare/Medicare-General-Information/ABN.html](https://www.cms.gov/Medicare/Medicare-General-Information/ABN.html)

**Thank you**

- To all of you for your attention on not the most exciting of topic in the world!
- To the MPTA for this wonderful opportunity to share knowledge!