Identifying appropriate delivery and utilization of physical therapy services

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Today’s topics

- CPT coding for Physical Therapy services
- Coding challenges for PT services
- Documentation elements that validate correct coding of PT services
- Documentation strategies that validate medical necessity of PT services

CPT Coding for Physical Therapy Services
97000 Series and Beyond

CPT Definitions

- **Time**
  - Is not intended to describe and/or prescribe the therapeutic dose
  - Is face to face time with the patient
  - 15 minutes is the most commonly described unit in the 97000 series
  - “A unit of time is attained when the mid-point is passed”
  - AMA CPT coding manual Introduction section
  - Time attributed to a specific CPT code is aggregated across the treatment session

Physical Medicine and Rehabilitation
97000 Series

- **Physical Medicine and Rehabilitation**
  - 97001 through 97799 within the scope of practice of licensed Physical Therapists (PT)
  - Some within the scope of work of a Physical Therapist Assistant (PTA)

Evaluation Services

- **PT evaluation - 97001**
  - Outside scope of a PTA
  - Required to develop a physical therapist plan of care (POC)
  - Not a timed code – bill 1 unit
97001 PT Evaluation

• Inclusive of all tests and measurements that would be considered part of a typical initial evaluation to establish a plan of care (POC).

Coding challenges/Payer policies:

• Per CMS Manual, Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting.
• Some commercial payers restrict IE to once per calendar year
  • Problematic for the PT in developing a plan of care

Evaluation Services

• PT re-evaluation - 97002
  • Outside scope of a PTA
  • Required to update a physical therapist POC
    • New tests and measurements
    • Change to long term goals
    • At discharge to summarize episode of care and promote coordination of care/transition to another setting/community
  • Not timed – bill 1 unit

Evaluation Code reform

• Anticipate new CPT codes for PT evaluation, possibly as early as 2017
• Low, Moderate, High complexity evaluations (History, Examination, Presentation; Decision making)

Modalities

• Modalities
  • Physical agents to change biologic tissue
• Two categories in AMA CPT coding:
  • Supervised and Constant Attendance

Supervised Modalities

CPT 97010-97028

• Do not require continuous one on one patient/provider contact
• Not timed codes
• One unit billed per treatment session even if more than one area is treated
Supervised application of a modality to one or more areas

- 97010 Hot or cold packs
- 97012 Mechanical traction
- 97014 Electrical stimulation, unattended
- 97016 Vasopneumatic device
- 97018 Paraffin bath
- 97022 Whirlpool therapy
- 97024 Diathermy therapy
- 97026 Infrared therapy
- 97028 Ultraviolet therapy

Supervised modalities do not require one on one contact...

- During the same time interval the same caregiver (PT or PTA) could bill patient A an unattended e-stim (97014) and be “one on one” with patient B, billing minutes of therapeutic exercise (97110)

Constant Attendance Modalities CPT 97032-97039

- Require direct one on one patient/provider contact
- Timed in 15 minute increments
- Total time billed is for one or more areas

Constant attendance modalities

- 97032 Electrical stimulation, manual
- 97033 Iontophoresis
- 97034 Contrast baths
- 97035 Ultrasound
  - Includes phonophoresis
- 97039 Unlisted modality (specify)

Modalities

- Constant Attendance
  - During the same time interval the same provider (PT or PTA) could not bill patient A minutes of ultrasound (97035) and patient B minutes of therapeutic exercise (97110)

Therapeutic Procedures

- Application of clinical skills and/or services to attempt to improve function
- Skilled services that do require one on one patient contact
- 97110 – 97546
- Time based
  - Units = 1 or more
Therapeutic Procedures require direct contact

- During the **same time interval** the same caregiver (PT or PTA) could not bill patient A minutes of manual therapy (97140) and patient B minutes of therapeutic exercise (97110)

Therapeutic Procedures (exception to “direct contact”)
Group 97150

- Application of clinical skills and/or services to attempt to improve function
- **Skilled service** that does not require one on one patient contact
- Requires constant attendance
  - One caregiver with more than one patient
  - PT or PTA
- Not time based
  - Units = 1 to each patient in the group
  - During the **same time interval** the same caregiver (PT or PTA) could bill one unit of 97150 to more than one patient

Active Wound Care Management

- Performed to remove devitalized and/or necrotic tissue and promote healing
- Skilled services that **do require** one on one patient contact
- 97597 – 97606
- Wound surface area based
  - “first 20 sq cm or less”
  - “each additional 20 sq cm or part thereof”

Tests and Measurements

- Tests in addition to routine evaluation tests and measures
- Data gathering within the scope of a PTA
- Report and impact on plan of care done by PT
- Skilled services that **do require** one on one patient contact
- 97597 – 97606

Orthotic Management and Prosthetic Management

- Skilled services that **do require** one on one patient contact
- 97760 – 97762

Other Procedures

- Unlisted physical medicine/rehabilitation service or procedure
- 97799
CPT Codes outside the 97000 Series

- Muscle and Range of Motion (ROM) Testing
  - Muscle
    - 95831 – 95834
  - ROM
    - 95851 – 95852
- Electromyography
  - EMG
    - 95860 - 95887
  - Nerve Conduction tests
    - 95905 - 95913

59 Modifier – Distinct Procedural Service –

- National Correct Coding Initiative (NCCI) coding edits
- Commonly used on Physical Therapy claims
- Definition for rehabilitation
  - "Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute intervals."

Challenge:

- Payer policies that limit effectively reporting CPT Codes that accurately reflect practice

Red Flags in Coding and Documentation

- No evaluation billed at beginning of episode – 97001
  - Required to identify medical necessity for physical therapy
  - Required to develop a plan of care
- Billing modalities only
- Excessive billing of modalities in absence of symptoms/impairments that respond to modalities
  - Too many (redundant)
  - Too long
- Routine billing of re-evaluation – 97002

CPT Coding Red Flags
CPT Coding Red Flags

• Miscoding unattended e-stim (97014) (G0283) as manual e-stim (97032)
  • 97014 and G0283 are set up and supervise
  • May treat another patient during the same time interval
  • Units = 1
  • 97032 is one on one with the patient during treatment
  • May not treat another patient during the same time interval
  • Units = 1 or more

• Documentation does not support the CPT codes on the claims
  • 97110 – “therapeutic exercises to develop strength and endurance, range of motion and flexibility”
  • you should see
  • Evaluation identifying qualified and quantified deficits in strength, endurance, range of motion or flexibility
  • Goals related to these deficits
  • Interventions (narrative or flow sheet) to address these deficits
  • Periodic reassessments of these deficits and progress toward related goals

CPT Coding Red Flags

• Aquatic therapy
  • 97113 – aquatic therapy with therapeutic exercise
  • Skilled service that does require one on one patient contact
  • Time based
  • Units = 1 or more
  • If more than one patient per PT or PTA. code to Group code
• 97150 - Therapeutic procedure(s), group (2 or more individuals)
  • Represents both land based and aquatic therapeutic procedures
  • Not time based
  • Units = 1 for each individual in the group

• Treatment sessions in excess of 90 minutes of service when patient presentation (complexities/comorbidities) doesn’t support intensity
• Documentation of treatment time does not support the number of CPT units billed

APTA Utilization Management Related Initiatives

• Documentation Guidelines (Resource Handout)
• Evidenced Based Practice (PT Now)
• Compliance
  • Registry
  • APTA Center for Integrity in Practice
  • Promote high quality care
  • Eliminate fraud, waste, abuse
  • Foster evidence based practice
  • Encourage ethical conduct/professionalism
  • Choosing Wisely Campaign
• UM/UR feedback form

Physical Therapy Outcomes Registry

The Physical Therapy Outcomes Registry is an organized system for collecting data to evaluate patient function and other clinically relevant measures for the population of patients receiving physical therapist services.
The registry will
• Provide information regarding practice patterns and variations in care;
• Assess clinical outcomes of physical therapy care;
• Examine associations between care and outcomes; and
• Inform clinical and policy decision-making.
Information will be available that will answer questions regarding provision of the “right care to the right patient at the right time.”

Choosing Wisely campaign
• APTA’s Choosing Wisely recommendations are designed to educate consumers about health care procedures that tend to be done frequently but whose usefulness in some scenarios has been called into question by evidence.

Choosing Wisely campaign
• The list is designed to spark thoughtful conversations between patients and their caregivers about the best, most effective care; it is not intended to prohibit any particular treatment in all scenarios or to dictate care decisions.

Choosing Wisely campaign
• As always, decisions about care should be made based upon the best available evidence, the clinical judgment of the physical therapist, and the preferences and goals of the patient.

Choosing Wisely campaign (Handout)
• Don’t employ passive physical agents except when necessary to facilitate participation in an active treatment program.

“Appropriate Delivery”
Patient/Client Management Model
Documentation: What are you looking for?

Documentation challenges

Unsubstantiated evidence of **medical necessity** and **skilled care** are two of the most common reasons for payment denial in rehab services.

Supporting codes/modifiers on the claim

Daily note/Treatment note

Documentation should support the CPT code selected and the time should support the # of units on the claim.

How can we support that our services were skilled

**Questions You Might Ask To Determine If A Service Is Skilled:**

1. What are the clinical skills and judgment being used for this intervention?
2. What is the complexity and sophistication of a particular intervention that requires the skills of a therapist or appropriately supervised PTA?
3. Could this skill be delivered without the skills of a therapist or appropriately supervised PTA?
4. What are the associated risks that require the skills of the therapist?
5. What specific instructions, assistance, or safety procedures require the skills of the therapist or supervised PTA?
“A therapist’s skills may be documented, for example, 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.

CMS Pub 100-02 Chapter 15 Section 220.3 B. Documentation Required

Support that the episode of care was medically necessary

How do you define “medical necessity” ???

APTA Position on Medical Necessity

- Determined by the licensed physical therapist based on the results of a physical therapy evaluation;
- Provided for the purpose of preventing, minimizing, or eliminating impairments, activity limitations, or participation restrictions;
- Requires the knowledge, clinical judgment, and abilities of the therapist and takes into consideration the potential benefits and harms to the patient/client; and is not provided exclusively for the convenience of the patient/client

APTA Position on Medical Necessity

- Considered medically necessary if the type, amount, and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals: to improve function, minimize loss of function, or decrease risk of injury and disease

Documenting to support medical necessity

Telling the story

The challenge is getting that clarity and “telling the story” in our documentation?

- Time constraints
- EMR/EHR limitations
- Bad habits
- PTs are better at treating than documenting ☺
Medical Necessity – condition of payment
• Care delivery requires the skills of a PT or appropriately supervised PTA
• Service is indicated for the dysfunction identified through evaluation
  • Functional deficits/functional goals
• Ongoing assessment
• Progressive interventions
  • Limited use of modalities
  • Exercise progression
• Progressive achievement of goals and improved function

Medically necessary?
Skilled... or not?

“Skilled services that are not adequately documented may appear to be unskilled.”

Questions/Comments?