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continued[®]

Medicare Part B Coding and Billing

For Occupational Therapy Services in Long-Term Care

Kathleen Weissberg, OTD, OTR/L

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continued[®]

Learning Outcomes

1. Discuss how clinical documentation creates a clinical picture of the patient's condition, justifies reimbursement and functions as a "receipt" for services rendered
2. Identify utilization of and documentation guidelines for commonly billed CPT codes
3. Define factors considered when coding the OT evaluation
4. Define how to accurately apply functional G codes

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Learning Outcomes

5. Describe how to select appropriate billing codes based on the plan of care
6. Describe how to accurately apply the 8-minute rule
7. Identify coding and billing “red flags” to be observant to when completing audits and completing daily charting
8. Describe the medical review process and strategies for management

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continued[®]

Importance of Documentation

- Must support medical necessity
- Paint a picture of the patient’s impairments/functional limitations
- Describe skilled therapy
- Justify frequency and duration
- Document treatment minutes
- Identify each specific skilled intervention to justify coding

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continued[®]

CPT Coding Guidance: Modalities

- Direct (one-on-one) contact means constant attendance
- Modalities are not generally stand-alone treatments
- Multiple heating modalities should not be used on the same day
- As symptoms subside/function improves, discontinue modalities
- Based on descriptors, these apply to one or more areas treated

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CPT Coding Guidance: 97010

- CPT 97010 - hot or cold packs (to one or more areas)
 - Bundled code; not separately paid
 - Supportive Documentation
 - The area(s) treated
 - The type of hot or cold application

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CPT Coding Guidance: 97024

- CPT 97024 – Diathermy
 - Indicated when a large area of deep tissues requires heat
 - Not R&N to perform BOTH thermal US and diathermy to the same region
 - Pulsed wave diathermy is covered for the same conditions as standard diathermy
 - Only 1 unit of CPT code 97024 is covered per date of service

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CPT Coding Guidance: 97024

- Supportive Documentation
 - Area(s) being treated
 - Objective clinical findings/measurements to support the need for a deep heat treatment
 - Subjective findings to include pain ratings, pain location, activities which increase or decrease pain, effect on function, etc.

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CPT Coding Guidance: 97032

- CPT 97032 – electrical stimulation (manual) (to one or more areas), each 15 minutes
 - Most non-wound care e-stim should be billed as G0283
 - 97032 is a constant attendance code
 - Direct motor point stimulation delivered via a probe
 - Instructing a patient in the use of a home TENS unit

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CPT Coding Guidance: 97032

- FES or NMES while performing a therapeutic exercise or functional activity may be billed as 97032
 - Do not bill additional CPT codes for the same time period
- Ultrasound with electrical stimulation provided concurrently is billed as ultrasound (97035)
- If the patient requires supervision for safety, this DOES NOT qualify as constant attendance
- Non-implantable pelvic floor electrical stimulators (e.g., vaginal or anal probes) may be billed as 97032
 - Stimulation delivered via electrodes should be billed as G0283

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CPT Coding Guidance: 97032

- Supportive Documentation
 - Type of electrical stimulation used (do not limit the description to “manual” or “attended”)
 - Area(s) being treated
 - If used for muscle weakness, objective rating of strength and functional deficits
 - If used for pain include pain rating, location of pain, effect of pain on function

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CPT Coding Guidance: 97035

- CPT 97035 – Ultrasound (to one or more areas)
 - May be pulsed or continuous width, in conjunction with other procedures, not as an isolated treatment
 - Indications:
 - limited joint motion requiring extensibility
 - symptomatic soft tissue calcification
 - neuromas
 - Phonophoresis is reimbursable by Medicare

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CPT Coding Guidance: 97035

- Supportive Documentation
 - Area(s) being treated
 - Frequency and intensity of ultrasound
 - Objective clinical findings such as measurements of range of motion and functional limitations to support the need for ultrasound
 - Subjective findings to include pain ratings, pain location, effect on function

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CPT Coding Guidance: G0283

- CPT G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
 - Most non-wound care electrical stimulation treatment provided in therapy should be billed as G0283
 - A supervised modality does not require direct (one-on-one) patient contact by the provider (e.g., IFC, TENS, Russian Stim)
 - Utilized with appropriate therapeutic procedures to effect continued improvement

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CPT Coding Guidance: G0283

- Supportive Documentation
 - Type of electrical stimulation used (e.g., TENS, IFC)
 - Area(s) being treated
 - If used for pain include pain rating, location of pain, effect of pain on function

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CPT Coding Guidance: Therapeutic Procedures

- Direct (one-on-one) patient contact
- Supervision of a previously taught exercise/program is not covered
- No separate coverage for time spent on documentation

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CPT Coding Guidance: 97110

- CPT 97110 - Therapeutic Exercises to develop strength and endurance, range of motion and flexibility (one or more areas, each 15 minutes)
 - Used for restoring strength, endurance, ROM, flexibility where loss/restriction causes functional limitation
 - Active, active-assisted, or passive participation
 - Skills of a therapist to evaluate, design, instruct
 - Repetition after successful teaching and monitoring is non-covered

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CPT Coding Guidance: 97110

- Exercises for fitness, flexibility, endurance in absence of a complicated condition are not covered
- Exercises not requiring skilled assessment are not covered
- Documentation must include measurable indicators AND impact on function
- Documentation should describe new exercises added or changes made to justify skill
- Show transition to HEP
- PROM is a short course to include caregiver training

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CPT Coding Guidance: 97110

- Supportive Documentation
 - Objective measurements of loss of strength and range of motion (with comparison to the uninvolved side) and effect on function
 - If used for pain include pain rating, location of pain, effect of pain on function
 - Specific exercises performed, purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills of a therapist were required
 - When skilled cardiopulmonary monitoring is required, include documentation of pulse oximetry, heart rate, blood pressure, perceived exertion, etc.

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CPT Coding Guidance: 97112

- CPT 97112 - Neuromuscular Re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (one or more areas, each 15 minutes)
 - R&N for:
 - loss of deep tendon reflexes and vibration sense
 - nerve palsy
 - muscular weakness or flaccidity
 - poor static or dynamic sitting/standing balance
 - postural abnormalities
 - loss of gross and fine motor coordination
 - hypo/hypertonicity

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CPT Coding Guidance: 97112

- For falls, documentation should indicate:
 - specific fall dates and/or hospitalization(s) and reason for the fall(s), if known
 - most recent prior functional level of mobility
 - cognitive status
 - prior therapy intervention;
 - functional loss due to the recent change in condition
 - balance assessments, LE ROM/MMT
 - patient and caregiver training
 - carry-over of therapy techniques

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CPT Coding Guidance: 97112

- Not R&N to extend visits to:
 - remind the patient to ask for assistance
 - offer close supervision of activities due to poor safety awareness
 - remind a patient to slow down
 - offer routine verbal cues for compensatory or adaptive techniques already taught
 - remind a patient to use an assistive device
 - train multiple caregivers

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CPT Coding Guidance: 97112

- Supportive Documentation
 - Objective loss of ADL, mobility, balance, coordination deficits, hypo- and hypertonicity, posture, effect on function
 - Specific exercises/activities performed (including progression)
 - Purpose of the exercises related to function
 - Instruction given, and/or assistance needed, to support that the skills of a therapist were required

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CPT Coding Guidance: 97113

- CPT 97113 - Aquatic Therapy with Therapeutic Exercises (one or more areas, each 15 minutes)
 - Any activity/exercise performed in water
 - R&N for ROM, strength, mobility, balance; persons who cannot tolerate land therapy
 - Exercises become repetitive quickly
 - Transition to land-based exercise ASAP
 - Only count skilled minutes; do not count time to dress/undress, get into and out of the pool, etc.

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CPT Coding Guidance: 97113

- Supportive Documentation
 - Justification for use of a water environment
 - Objective loss of ADLs, mobility, ROM, strength, balance, coordination, posture and effect on function
 - If used for pain include pain rating, location of pain, effect of pain on function
 - Specific exercises/activities performed (including progression of the activity), purpose of exercises as related to function, instructions given, and/or assistance needed to perform exercises to demonstrate that the skills and of a therapist were required

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CPT Coding Guidance: 97140

- CPT 97140 - Manual Therapy Techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
 - Joint mobilization (peripheral and/or spinal)
 - Myofascial release/soft tissue mobilization
 - Manipulation
 - Manual lymphatic drainage/complex decongestive therapy (MLD/CDT)

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CPT Coding Guidance: 97140

- Manual lymphatic drainage/complex decongestive therapy (MLD/CDT)
 - Primary and secondary lymphedema
 - Coverage if these conditions are met:
 - physician-documented diagnosis of lymphedema (primary or secondary)
 - documented signs or symptoms of lymphedema
 - the patient or patient caregiver has the ability to understand and comply with the continuation of the treatment regimen at home

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CPT Coding Guidance: 97140

- Supportive Documentation
 - Area(s) being treated
 - Soft tissue or joint mobilization technique used
 - Objective and subjective measurements of areas treated and effect on function
 - For MLD/CDP:
 - medical history, comorbidities, prior treatment
 - cognitive and physical ability for carryover
 - limitation of function/PLOF
 - limb measurements and description of skin

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CPT Coding Guidance: 97530

- CPT 97530 - Therapeutic Activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
 - Movement activities can be for a specific body part or could involve the entire body.
 - Involves functional activities to restore functional performance in a progressive manner
 - Directed at a loss or restriction of mobility, strength, balance, or coordination
 - Directed at a specific outcome

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CPT Coding Guidance: 97530

- In order to be covered:
 - documented condition for which TA can be expected to restore function
 - clear correlation between type of TA and underlying medical condition
 - condition is such that he/she is unable to perform the therapeutic activities without skilled intervention

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CPT Coding Guidance: 97530

- Supportive Documentation
 - Objective measurements of loss of ADLs, balance, strength, coordination, range of motion, mobility and effect on function
 - Specific activities performed, and amount and type of assistance to demonstrate that the skills and expertise of the therapist were required

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97530 vs. 97110

- Which code should you use?
 - 97530 involves the use of functional activities to restore functional performance in a progressive manner
 - 97110 involves **exercises** for the purpose of restoring strength, endurance, range of motion and flexibility where a documented loss or restriction is documented

97530 has a functional component very much in line with the scope of practice for OT

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Choosing Wisely ®

- Don't provide intervention activities that are non-purposeful
 - "Our profession was founded on the premise of using meaningful and purposeful activity as the foundation for therapy. Our profession's research supports the use of purposeful activities over the use of non-purposeful activities. Survey research confirms ... that preparatory interventions are used to a greater extent than authentic occupations. Use of occupation is inherently more intellectually challenging and requires creativity."

--Glen Gillen

(Richardson, 2018)

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CPT Coding Guidance: 97535

- CPT 97535 Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
 - Training should be focused on a functional limitation(s) in which there is potential for improvement in a functional task that will be meaningful to the patient and the caregiver
 - The patient and/or caregiver must have the capacity and willingness to learn from instruction
 - Used for ADL, safety procedures, and instructions in the use of adaptive equipment and assistive technology for use in the home environment

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CPT Coding Guidance: 97535

- Not used globally for all home instructions
 - Use the code that best describes the focus of the self management activity
- Many ADL/IADL impairments require a therapist to evaluate, design a program, and instruct in safe completion
 - Repetitious completion of the activity, once taught and monitored, is non-covered care
- Documentation needs to clearly support skilled necessity
 - Progression in the technique to more complex or less patient dependence shows the technique remains skilled
- Documentation must not show that the patient is practicing techniques already taught

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CPT Coding Guidance: 97535

- Supportive Documentation
 - Objective measurements of the patient's activity of daily living (ADL)/instrumental activity of daily living (IADL) impairment to be addressed
 - The specific ADL and/or compensatory training provided, specific safety procedures addressed, specific adaptive equipment/assistive technology utilized, instruction given and assist required (verbal or physical), and the patient's response to the intervention, to support that the services provided required the skills and expertise of a therapist

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CPT Coding Guidance: 97542

- CPT 97542 - Wheelchair Management (e.g., assessment, fitting, training), each 15 minutes
 - Assessment for non-specialized wheelchairs, cushions, lapboards, etc. w/o complicating condition is not skilled
 - If pt. can self-correct, not skilled
 - Care turned over to caregivers ASAP
 - Ongoing visits for increasing sitting times not R&N
 - Visits for restraint reduction are generally non-covered
 - Expected that multiple seating deficits discovered during the initial evaluation would be treated concurrently

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CPT Coding Guidance: 97542

- Supportive Documentation
 - Describe the interventions to show that the skills of a therapist were required. For example, describe the various wheelchair adaptations trialed and the patient's response to the intervention. If training is provided, describe the type of training, the amount of assistance required and the patient response to the training.

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CPT Coding Guidance: 97760

- CPT 97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
 - Not reported with 97116 for the same extremity
 - May be prefabricated or custom-fabricated.
 - For uncomplicated conditions, these are not R&N
 - Issuing off-the-shelf splints for foot drop or wrist drop
 - Issuing off-the-shelf foot or elbow cradles for routine pressure relief
 - Issuing “carrots” or towel rolls for hand contractures
 - Bed positioning (e.g., pillows, wedges) to relieve potential pressure

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CPT Coding Guidance: 97760

- Repetitive range of motion prior to placing an orthotic/positioner to maintain the range of motion is not reasonable and necessary
- Ongoing therapy visits for increasing wearing time are generally not reasonable and necessary
- Ongoing visits are billed with CPT 97763

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CPT Coding Guidance: 97760

- Supportive Documentation
 - A description of the patient's condition (including applicable impairments and functional limitations) that necessitates an orthotic
 - Any complicating factors
 - The specific orthotic provided and the date issued
 - A description of the skilled training provided
 - Response of the patient to the orthotic

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CPT Coding Guidance: 97761

- CPT 97761 - Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
- Includes preparation of the stump, skin care, modification of prosthetic fit, initial mobility
 - Gait training with the prosthesis coded with 97116
 - Supportive Documentation
 - Type of prosthesis, extremity involved
 - Specific training provided and amount of assistance needed
 - Any complicating factors and specific description of these (with objective measurements), such as pain, joint restrictions/contractures, strength deficits, etc.

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CPT Coding Guidance: 97763

- CPT 97763 - Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
 - Established patients who have already received their orthotic or prosthetic device.
 - Supportive Documentation
 - Reason for assessment
 - Findings from the assessment
 - Specific device, modifications made, instruction given

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CPT Coding Guidance: G0515

- CPT G0515 Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training) direct (one-on-one) patient contact, each 15 minutes
 - Designed to improve attention, memory, and problem-solving, including the use of compensatory techniques
 - For patients with acquired cognitive deficits resulting from head trauma, or acute neurologic events including cerebrovascular accidents
 - Conditions without potential for improvement or restoration, such as chronic progressive brain conditions, would not be appropriate

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CPT Coding Guidance: G0515

- Cognitive skills are an important component of many tasks
- May be better reported using other codes (such as 97535)
- Many LCDs limit coverage of G0515 to very specific ICD-10 codes and medical conditions

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CPT Coding Guidance: G0515

- Supportive Documentation
 - Objective assessment of the patient's cognitive impairment and functional abilities
 - Prognosis for recovery of the specific impaired cognitive abilities (remediation)
 - A determination of a range of compensatory strategies that the individual can realistically utilize to improve daily functioning in a meaningful way
 - Specific cognitive activities performed, amount of assistance, and the patient's response to the intervention, to demonstrate that the skills and expertise of the therapist were required

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Plan of Care

Knowing where we are (current function) and where we want to go (patient-centered, functional goals)...

- What path will we travel (CPT selection)?
- How long will it take (frequency/duration)?

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Purpose of the Evaluation

- Document the necessity of a course of therapy through objective findings and subjective patient/caregiver self-reporting
- Clearly describe the presenting complaint or problem for which the patient is seeking services
- Only one initial evaluation code should be used, reflecting the level of complexity of the evaluation, and all presenting complaints and problems evaluated

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continued

Consider the Following

- Do not bill for a therapy evaluation on more than one date of service
- Do not bill therapy screenings utilizing the evaluation codes
- Pre-operative evaluations are non-covered
- If treatment is given on the same day as the initial evaluation, it the treatment is billed using the appropriate CPT codes

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continued

Consider the Following

- Patient must be present and active for any time that is coded as an evaluation
- Record actual face to face time with the patient
- Cannot include time spent in documentation, chart review, etc.

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continued

Evaluation vs. Treatment

- Assessment determines level of deficit
- Once you are no longer determining the deficit area but instead are providing an intervention, you have moved into treatment
- Compensatory strategies/modifications are interventions
- Family communication and goal planning can be moved to the first treatment session
- There is often not a hard stop between evaluation and treatment and you find that you go back and forth between the two during your initial visit with the patient
 - Use clinical judgment to determine how to capture your time
- Focus on function! Complete your baseline assessment and be prepared to begin addressing function to prepare for discharge.

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Frequently Asked Questions

- What minutes can be recorded for evaluation?
 - Only those minutes the patient is present and participating in assessment and examination and patient interview
- What tasks cannot be recorded for evaluation?
 - Chart/record review, obtaining Dr. orders, documentation, including the care plan in PCC, unless the patient is present and engaged in the task

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Frequently Asked Questions

- What minutes can be recorded for treatment?
 - Only those minutes the patient is present, participating and has therapeutic value to the patient
- When does evaluation end and treatment begin?
 - The evaluation ends when the therapist determines the patient's current level of assist for a task and treatment starts when the therapist provides skilled services that include strategies, education, techniques, and interventions to improve the evaluated task

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Re-Evaluation

- Reevaluations are distinct from routine therapy assessments
- Indications for a reevaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care
- Documentation must support the need for a re-evaluation
- Therapy reevaluations should contain all the applicable components of an initial evaluation and must be completed by a therapist
- A reevaluation is not a routine, recurring service. Do not bill for routine reevaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report.

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CPT Definition

- “Occupational therapy evaluations include an occupational profile, medical and therapy history, relevant assessments, and development of a plan of care, which reflects the therapist’s clinical reasoning and interpretation of the data.”
- Use of standardized tests and measures
- Corresponds to the Occupational Therapy Practice Framework (OTPF)

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Code Language and Levels

- CPT describes exactly what must be done in an evaluation
 - Occupational profile and client history (medical and therapy)
 - Assessment of occupational performance
 - Clinical decision making
 - Development of plan of care
- Each factor is “scored”
- Documentation **must** support your choices

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continued

Important!!

- OT eval doesn't ONLY contain these 3 elements, must be comprehensive
- Documentation must support levels
- In order to move to a higher level of evaluation **all three components must be of the higher level**

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continued

Profile and History

Was an occupational profile completed? How complex is the client history (medical and therapy)?

- Who is the client?
- Why is the client seeking services? Concerns relative to occupations and daily life activities?
- What occupations are successful, problematic?
- What context/environment support or inhibit?
- Client's occupational history (values, interests, life experiences, patterns of engagement, meaning)?
- Client's priorities and desired outcomes?

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continued

Profile and History

- Level is determined by how involved the profile **and** the medical history are
 - Consider presenting problem, reason for referral, client goals
- Code descriptor looks at whether these elements are **problem focused, detailed, or comprehensive**
 - Brief (Low Complexity)
 - Expanded (Moderate Complexity)
 - Extensive (High Complexity)

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Profile and History

CPT Code	CPT Description
Low Complexity (97165)	An occupational profile and medical and therapy history, which includes a <u>brief</u> history including review of medical and/or therapy records relating to the presenting problem.
Moderate Complexity (97166)	An occupational profile and medical and therapy history, which includes an <u>expanded</u> review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance.
High Complexity (97167)	An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and <u>extensive</u> additional review of physical, cognitive, or psychosocial history related to current functional performance.

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continued

Assessment of Occupational Performance

- How is the assessment of activity restrictions described? How are performance deficits defined, identified and counted?
- Identification of performance deficits **resulting in activity or participation restrictions**
- Ideally use standardized assessments
- Decide with the client if a deficit will be addressed

The evaluation must clearly document the deficit, how it impacts activity or participation and how it was assessed

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Assessment of Occupational Performance

CPT Code	CPT Description
Low Complexity (97165)	A assessment(s) that identifies <u>1-3 performance deficits</u> (i.e., relating to physical cognitive or psychosocial skills) that result in activity limitations and/or participating restrictions.
Moderate Complexity (97166)	A assessment(s) that identifies <u>3-5 performance deficits</u> (i.e., relating to physical cognitive or psychosocial skills) that result in activity limitations and/or participating restrictions.
High Complexity (97167)	A assessment(s) that identifies <u>5 or more performance deficits</u> (i.e., relating to physical cognitive or psychosocial skills) that result in activity limitations and/or participating restrictions.

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continued

Performance Deficits

- Result in activity limitations, participation restrictions
- Documentation **must** show the deficit **AND** how it affects participation
- Inability to complete activities DT lack of skills
 - Physical Skills (impairments of body structure or function)
 - Cognitive Skills (ability to attend, perceive, think, understand, problem solve, etc.)
 - Psychosocial Skills (interpersonal interactions, habits, routines and behaviors)

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Level of Clinical Decision Making

- What skills must the therapist use? How difficult is the work of the therapist? What aspects of the client affect the decision making intensity?
- Clinical reasoning should be well documented throughout the evaluation to support the level chosen in this area

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Level of Clinical Decision Making

CPT Code	CPT Description
Low Complexity (97165)	Clinical decision making of <u>low complexity</u> , which includes an analysis of the occupational profile, analysis of data from <u>problem-focused assessment(s)</u> , and consideration of a <u>limited number</u> of treatment options. Patient presents with no comorbidities that affect occupational performance. <u>Modification</u> of tasks or assistance (e.g., physical or verbal) with assessment(s) is <u>not necessary</u> to enable completion of evaluation component.

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Level of Clinical Decision Making

CPT Code	CPT Description
Moderate Complexity (97166)	Clinical decision making of <u>moderate analytic complexity</u> , which includes an analysis of the occupational profile, analysis of data from <u>detailed assessment(s)</u> , and consideration of <u>several treatment options</u> . Patient may present with comorbidities that affect occupational performance. <u>Minimal to moderate modification</u> of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable completion of evaluation component.

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Level of Clinical Decision Making

CPT Code	CPT Description
High Complexity (97167)	Clinical decision making of <u>high analytic complexity</u> , which includes an analysis of the occupational profile, analysis of data from <u>comprehensive assessment(s)</u> , and consideration of <u>multiple treatment options</u> . Patient may present with comorbidities that affect occupational performance. <u>Significant modification</u> of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.

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Level of Clinical Decision Making

- Assessment Process
- Level of analysis and assessment
 - Low Complexity (97165) Analysis of data from problem-focused assessment(s)
 - Moderate Complexity (97166) Analysis of data from detailed assessment(s)
 - High Complexity (97167) Analysis of data from comprehensive assessment(s)

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Level of Clinical Decision Making

- Comorbidities
- The type, number, and complexity of comorbidities affecting occupational performance or that result in participation restrictions are identified as affecting the evaluation code level

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Level of Clinical Decision Making

- Assessment Modification and Need for Assistance
- Modification of directions, task complexity, environment, time, or other factors – physical or verbal
 - Low Complexity (97165) Modification of tasks or assistance is not necessary
 - Moderate Complexity (97166) Minimal to moderate modification of tasks is necessary
 - High Complexity (97167) Significant modification of tasks or assistance is necessary

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Level of Clinical Decision Making

- Selection of Interventions
- Selecting from multiple options as opposed to considering limited options raises the level of clinical decision making
 - Low Complexity (97165) Consideration of a limited number of treatment options
 - Moderate Complexity (97166) Consideration of several treatment options
 - High Complexity (97167) Consideration of multiple treatment options

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Level of Clinical Decision Making

- Plan of Care
- Final step in evaluation
- Written after all information is gathered and analyzed from the client's history, occupational profile, performance deficits that result in activity limitation and/or performance restrictions, and standardized and non-standardized assessments

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Re-Evaluation (97168)

CPT Code Components	CPT Description
Assessment	An assessment of changes in patient functional or medical status with revised plan of care.
Occupational Profile	An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals.
Plan of Care	A revised plan of care

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Defending Appropriate Levels of Evaluation Codes

- Approach the evaluation comprehensively
- Code components must be identified and justified in the documentation
- The evaluation is based upon intensity and complexity of the client's performance deficits
- Be aware of and familiar with the OT Practice Framework

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Benefits of ICD-10

- Improved specificity
- Availability to add new codes
- Use of full code titles
- Expands on combination codes

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ICD-10 Code Structure

- Characters 1-3: Category
- Characters 4-6: Etiology, anatomic site, severity or other clinical detail
- Character 7: Extension

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CONTINUED

ICD-10 Affects the Selection of a Diagnosis Code

- ICD-10 is about coding the correct patient diagnoses
- If the diagnosis doesn't match the services provided, the billed services are at risk for denials
- It is essential to code for medical necessity

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CONTINUED

What is Medical Necessity?

- Service must be reasonable and necessary to diagnosis or treat a patient's medical condition
- The diagnosis codes reported with the service tells the payer "why" a service was performed
- The diagnosis codes reported helps support the medical necessity of the service provided

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CONTINUED

Medical vs. Treatment Diagnosis

- Primary (Medical) diagnosis must be a pertinent, documented, medical condition
- Primary (Medical) diagnosis is the disease, illness, condition or injury the patient has suffered
- Treatment diagnosis is the reason/problem for which therapy services are rendered
- Treatment diagnosis is caused by the Primary diagnosis in most instances

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Medical Diagnosis Part B

- The medical diagnosis code/s must be supported by the medical record documentation and relate to the therapy treatment diagnosis
- It should be taken from the facility face sheet in the patient's medical record or physician progress notes if recent physician visit prompted referral
- May vary from one discipline to another
- If there isn't a medical diagnosis to support a treatment diagnosis, ask the physician for a specific code

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continued

Treatment Diagnosis

- Determined by the evaluating therapist based off evaluation/assessment
- Must be discipline specific
- Should reflect the client's recent impairments that have been assessed and short and long term goals established to address the impairments
- Often there will be more than one treatment diagnosis

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continued

What are the Basic Steps in Selecting the Codes?

- You will find this information at *ICD 10 Official Guidelines for Coding and Reporting*
- Locate the term that best identifies the reason for visit in the *Alphabetical Index*
- Verify the code to the greatest level of specificity in the *Tabular Index*

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continued

continued

Key Steps for Choosing a Correct TX Diagnosis

- Step 1
 - Assess impairments and document your findings
 - Establish and document related short and long term goals
 - Select the treatment codes and check the definitions to ensure they match the impairments
 - Make sure selected codes are MAC/LCD approved if applicable

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continued

Key Steps for Choosing a Correct TX Diagnosis

- Step 2
 - ICD-10 codes chosen must be medically necessary, appropriate and relate to the therapy discipline specific service

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continued

Key Steps for Choosing a Correct TX Diagnosis

- Step 3
 - Distinguish between a medical diagnosis and a treatment diagnosis

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continued

Key Steps for Choosing a Correct TX Diagnosis

- Step 4
 - Therapy documentation must support the following:
 - Dominant side
 - Anatomic detail
 - Site specificity
 - Specific body part
 - Thorough assessment of functional deficits and impairments, barriers identified and POC
 - Include information from the ICD-10 description

86

continued

continued

What Codes are Being Flagged for ADR?

- OT
 - Muscle Weakness M62.81

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continued

M62.81 (Muscle Weakness)

- Therapists often use the underlying impairment of muscle weakness for a treatment diagnosis
- Muscle weakness causes many functional deficits and impacts every aspect of the therapy plan of treatment
- Therapists treat a multiple of underlying impairments and functional deficits such
- There are many codes to choose from

88

continued

When should I use M62.81 (Muscle Weakness)?

- Code describes weakness in multiple anatomic sites
- This code is not appropriate for weakness that exists in a specific location
- The therapist should code for the underlying condition causing the muscle weakness

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continued

How do I Code for a Weakness in a Specific Area?

- M62.81 is not be appropriate if the client is experiencing weakness in one specific area
- To code for weakness in a specific area, use the appropriate atrophy code
- Therapists should code first for the underlying cause of the weakness

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continued

Documentation of M62.81

- Needs to be backed up by documentation
- Needs specific documentation of specific muscle weakness
 - Examples: Myasthenic and Quadriparesis

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How Can I Make M62.81 Specific?

- Offers no specificity as to what is weak and why
- Additional tx dx codes will be used to support this code
- Use of an external cause code is needed to identify the cause of the musculoskeletal condition
 - External Cause codes (V00-Y99) are from Chapter 20

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Take Aways ...

- M62.81 is not appropriate for weakness in a specific location
- M62.81 cannot stand alone – MACs are flagging this
 - Additional clinical information that further describes WHY they have weakness
 - This is in addition to clearly painting this picture in the evaluation
- If strength is not 3/5 or less, this code is not appropriate

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"Other"	<ul style="list-style-type: none"> • Used when the information in the medical record provides detail for which a specific code does not exist • Alphabetic index entries with NEC in the line designate "other" codes in the Tabular list • Alphabetic index entries represent specific diseases where no specific code exists so it is included within an "other" code
"Unspecified"	<ul style="list-style-type: none"> • Use when the information in the medical record is insufficient to assign a more specific code • For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified
Includes Notes	Appears immediately under a three character code title to further define, or give examples of, the content of the category

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Excludes1 Definition

- A Type 1 excludes note is a pure excludes note
- It means “NOT CODED HERE!”
- Excluded diagnosis should never be used with the code you are looking up
- Codes are mutually exclusive so they are NEVER used together
 - E.g., Z47 Orthopedic aftercare excludes aftercare for healing fracture

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Excludes2 Definition

- Means “NOT INCLUDED HERE!”
- The excluded condition is not part of the condition it is excluded from, a patient may have both conditions at the same time
- May be acceptable to use both the code and the excluded code together if supported by medical record documentation
 - E.g., Z43 Encounter for artificial openings excludes2 fitting and adjustment of prosthetic and other devices (Z44-Z46)

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Categories of Z Codes

- Status codes
 - Status may affect the course of treatment and its outcome (e.g., Z78.1 Physical restraint status)
- History (of) codes
 - Used in conjunction with other codes (e.g., Z91.81 History of falling)
- Aftercare
 - Patient requires continued care during healing or recovery (Z47 Orthopedic aftercare)
- Z Codes must be supported by other codes – often flagged when used as “stand-alone codes”

97

Question

- What's the difference between the ICD-10 extension D and extension S (sequela)?
 - The seventh character indicates:
 - A – Initial encounter
 - D – Subsequent encounter
 - S – Sequela
- Subsequent encounters occur after the patient has received active treatment of the injury and is receiving routine care for the injury
- Sequela are the late effects of an injury

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continued

Where can I find a list of the codes associated with each NCD and LCD?

- Visit the CMS ICD-10 website for transmittals that contain code updates for NCDs
- LCDs can be found in the Medicare Coverage Database

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continued

Side Note ...

ICD-10 coding of medical and treatment conditions will play critical role with new Medicare Part A Patient Driven Payment Model (PDPM)

100

continued

continued

Modes of Therapy Individual Therapy

- The treatment of one resident at a time
- The resident receives the therapist's full attention
- Treatment individually at intermittent times during the day is individual treatment and is added for the daily count

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continued

Modes of Therapy Concurrent Therapy

- No concurrent therapy for Medicare Part B
- The treatment of two or more residents at the same time is documented as group treatment

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continued

continued

Modes of Therapy

Group Therapy

- Therapy treatment provided simultaneously to two or more patients who may or may not be doing the same activities
 - For example, therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time

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continued

Therapy Students

Medicare Part B

The following criteria must be met in order for services to be billed. The qualified professional is:

- Present and in the room for the entire session
- Directing the service, making the skilled judgment and is responsible for the assessment and treatment
- Not engaged in treating another patient or doing other tasks at the same time
- Responsible for the services and signs all documentation
 - Student may also sign, but this is not required
- PTAs/COTAs can serve as clinical instructors under their scope of practice and supervision of a PT/OTR

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continued

CMS Regulations for Counting Minutes of Therapy on MDS

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility
- The therapist's time spent on initial evaluation is not included on the MDS
- The therapist's time spent on documentation is not included unless point of service
- Time spent on subsequent reevaluations should be counted on the MDS
- Family education when the resident is present is counted and must be documented in the resident's record

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continued

CMS Regulations for Counting Minutes of Therapy on MDS

- Only skilled therapy time shall be recorded on the MDS
- Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included
- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident

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continued

CONTINUED

CMS Regulations for Counting Minutes of Therapy on MDS

- Skilled therapy services must meet all of the following conditions
 - For Part B the plan of care must be certified by a physician following the therapy evaluation;
 - Services must be directly and specifically related to an active written treatment plan that is approved by the physician;
 - Level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
 - Expectation that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
 - Accepted standards of medical practice; and,
 - Reasonable and necessary

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CONTINUED

CMS Regulations for Counting Minutes of Therapy on MDS

- Include services provided by a qualified occupational/physical therapy assistant under the direction of a qualified OT/PT
- Record the actual minutes of therapy
 - Do not round therapy minutes to the nearest 5th minute
- When therapy is provided, staff needs to document the different modes of therapy. It is important to keep records of time included for each.

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Utilization Guidelines: CPT

- Untimed CPT Codes
 - Not defined in the AMA CPT Manual by a specific time frame (such as “each 15 minutes”)
 - Based on the number of times the procedure is performed, often once per day
- Timed CPT Codes
 - Direct (one-on-one) time
 - Generally 15 minute increments

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CPT Coding: “8 Minute Rule”

- Applies to CPT codes timed in 15-min increments only
- For any single CPT code, bill appropriate number of units based on specified time intervals
- If more than one 15-min timed code is billed on a calendar day, the total number of units that can be billed is constrained by the total treatment time

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continued

“8 Minute Rule”

- 1 unit > 8 minutes through 22 minutes
- 2 units > 23 minutes through 37 minutes
- 3 units > 38 minutes through 52 minutes
- 4 units > 53 minutes through 67 minutes
- 5 units > 68 minutes through 82 minutes
- 6 units > 83 minutes through 97 minutes
- 7 units > 98 minutes through 112 minutes
- 8 units > 113 minutes through 127 minutes

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continued

Documenting Treatment Time

- Do not record as “Time in/Time out”
- Do not “round” minutes; record the actual treatment time
- Do not record “units” of treatment, instead of minutes
- Do not include unbillable time (e.g., changing, waiting, resting, toileting)

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continued

continued

Keep in Mind ...

- Miscoded services may lead to denial
- Do not bill for documentation time separately
- Do not code higher than what the procedure requires
- Do not select the code based on reimbursement
- Do not “unbundle” services/procedures
- Do not bill separately for supplies
- Co-treatment is not permitted for Part B

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continued

Therapy Documentation

Only those modalities/procedures that can be verified in the medical record as rendered can be considered for payment



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continued

Treatment Notes

- Required for every treatment day/service to justify codes/units on the claim
 - Must include:
 - date of treatment
 - identification of each specific treatment, intervention or activity provided in language that can be compared with the CPT codes to verify correct coding
 - record of the total time spent in services represented by timed codes under timed code treatment minutes
 - record of the total treatment time in minutes, which is a sum of the timed and untimed services
 - signature and credentials of each individual(s) that provided skilled interventions

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National Correct Coding Initiative (NCCI)

- NCCI edits implemented to provide additional guidance billing
- Edits may be bypassed if the required modifier is present on the claim **and** documentation supports the use of the modifier and the medical necessity of treatment
 - Modifier -59 indicates distinct procedural service
 - Modifier -KX indicates services related to Part B threshold
 - Still required even though cap has been lifted

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CCI Edit Example

- Billing record:
 - 2 units 97530, ther act
 - 1 unit 97535-59, self-care
- Documentation to support modifier -59:
 - Transfer training bed to wheelchair w/ facilitation of weight shift over involved LE, focus on eccentric control of quads during sit to stand **followed by** home management re-training in the kitchen addressing energy conservation strategies and work simplification

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Part B Cap Repealed

- Even though the Part B Cap was repealed, the therapist still needs to clearly document the:
 - Medical necessity/need for services
 - Condition and complexities affecting treatment
 - Skilled service provision to support medical necessity
- Nursing documentation must support therapy
- Claims are still subject to targeted medical review above the threshold

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continued

G-Codes and Severity Modifier Reporting

- Need for G Codes removed with repeal of Part B Cap
- Still required through CY2018
- Will not be needed after January 2019

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continued

G-Codes and Severity Modifier Reporting ... For Now

- Applies to **ALL** Medicare Part B therapy claims
- Applies to **ALL** therapy settings
- Non-payable G-codes with severity modifiers are submitted with billing claim
 - Correlate to current and projected functional status

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continued

Reporting Requirements

- Therapists will report on **only ONE** functional limitation at the beginning of therapy
 - If therapy continues after this treatment goal is achieved/functional limitation is resolved, the therapist will select a different limitation to report
- This does **NOT** mean the therapist must treat only one condition/functional limitation at a time
- This does not limit multiple disciplines reporting on the same limitation at the same time

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Reporting Requirements

- The G-code chosen should be:
 - The most appropriate as determined by the therapist; **AND**
 - Most closely relate to the most clinically relevant functional limitation at the time of the initial therapy evaluation & establishment of the POC; **AND/OR**
 - Be one that would yield the quickest &/or greatest change; **AND/OR**
 - Be the one that is the greatest priority for the patient.

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PT & OT G-Codes

Code	Descriptor
Mobility: Walking & Moving Around G8978, G8979, G8980	<ul style="list-style-type: none"> • Short & long distances; different surfaces; around obstacles • Climbing, crawling, running, jumping, swimming • Moving around in home, outside home/building • Using equipment (wheelchair), using transportation
Changing & Maintaining Body Position G8981, G8982, G8983	<ul style="list-style-type: none"> • Changing/maintaining a basic body position: bed mobility, lying down, squatting, kneeling, sitting, standing, bending, shifting center of gravity, other • Transferring oneself: while sitting, while lying, other

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PT & OT G-Codes

Code	Descriptor
Carrying, Moving & Handling Objects G8984, G8985, G8986	<ul style="list-style-type: none"> • Lifting & carrying objects: in hands, arms, with shoulder, hip, back, on head, putting objects down (home management-cooking, cleaning) • Moving objects with LEs: pushing, kicking • Hand & arm use: picking up, grasping, manipulating, releasing, fine hand use, throwing, reaching, push, pull, catching
Self Care G8987, G8988, G8989	<ul style="list-style-type: none"> • Washing/drying oneself, caring for body parts (skin, teeth, hair, nails), toileting • Dressing (choosing appropriate clothing, donning/doffing, footwear), eating, drinking • Looking after one's health

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PT & OT G-Codes

Code	Descriptor
Primary Other G8990, G8991, G8992	<ul style="list-style-type: none"> Other physical or occupational therapy functional limitation (wound care, continence improvement, contracture management, etc.)
Subsequent Other G8993, G8994, G8995	<ul style="list-style-type: none"> Other physical or occupational therapy functional limitation Only use as a 2nd code after primary "other"

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Severity Modifiers

Modifier	Impairment Limitation Restriction
CH	0% impaired, limited or restricted
CI	At least 1% but <20% impaired, limited, restricted
CJ	At least 20% but <40% impaired, limited, restricted
CK	At least 40% but <60% impaired, limited, restricted
CL	At least 60% but <80% impaired, limited, restricted
CM	At least 80% but <100% impaired, limited, restricted
CN	100% impaired, limited or restricted

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Severity Modifiers

- Therapist must document in the medical record how they made the modifier selection so the same process can be followed at successive assessment intervals
- Use the “CH” modifier (0% impairment) when the therapy services provided are not intended to treat a functional limitation (e.g., wound care)

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Severity Modifiers

- In cases where the beneficiary's improvement is expected to be limited or when the therapist does not expect improvement (e.g., maintenance to prevent decline), the same modifier may be used for current status and projected goal status

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Documentation Requirements

- The clinician documents, on the applicable dates of service, the specific non-payable G-codes & severity modifiers reported on the claim, including how the selection was made—such as, where the therapist:
 - Uses clinical judgment to determine the modifier
 - Uses a standardized assessment
 - Uses a functional assessment tool

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Reporting Requirements

- Two G-codes are reported each time
 - Current/discharge status
 - Goal status
- Documentation must be completed by the clinician furnishing the service
 - Therapist assistants cannot determine G-codes and modifiers

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Reporting Requirements

- Initial evaluation
- 10th visit Progress Report
- Evaluative procedure/re-evaluation
- Discharge
- If reporting ends on a limitation and therapy will continue
- When reporting is begun on a different limitation in the same episode of care

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Affordable Care Act Provisions

- New resources to fight fraud
 - \$350 million over 10 years
 - Health Care Fraud and Abuse Control
- Expanded overpayment recovery efforts
 - Failure to return overpayments
 - RAC expansion

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Medical Review

- Medical Review Process
 - A healthcare investigator reviews the documents submitted to determine whether the services are covered
 - Has all the requested documentation been sent?
 - Is there a timely and complete certification/re-certification for this claim period?
 - Is the Plan of Treatment current and complete for all the treatments rendered?

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Medical Review

- Medical Review Process
 - Does the therapy meet Medicare guidelines?
 - Is the treatment reasonable (intensity/frequency/duration and necessary diagnosis codes)?
 - Does the treatment require the skill of a qualified therapist?
 - Is the patient making significant progress?
 - Are the services and number of units billed on the claim reflected in the medical record?

134

Medical Review

- Who are the agencies?
- What are they auditing?
- How do we manage the medical review process?
- How can we prepare?

135

Reviewing Body	Type of Claims	Selection Process	Volume of Claims	Purpose of Review
MAC	All	Targeted	Dependent on # of claims with improper payments	Prevent future improper payments
CERT	All	Random	Small (120,000)	Measure improper payments
RAC	All	Targeted	Dependent on # of claims with improper payment	Detect & correct past improper payments
ZPIC	All	Targeted	Dependent on # of potential fraud claims	Identify potential fraud
OIG	All	Targeted	Dependent on # of potential fraud claims	Identify fraud

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continued

Types of Review

- Probe review
 - Provider-specific
 - Widespread probe
- Pre-pay review
- Post-pay review
- Targeted medical review (TMR)

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continued

Managing the Review Process

- Know state practice acts/survey guidelines
- Identify MAC; review LCDs and NCDs
- MAC diagnosis to treatment edits
- Timely response to all requests (30 days for ADR)
- Documentation **must** support services billed

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continued

continued

Why are Claims Denied?

- Medical necessity
- CPT codes do not reflect services provided
- Unit to minute conversion
- Therapy does not follow LCD
- Nursing documentation does not support therapy

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continued

Why are Claims Denied?

- Re-evaluation
- Services not reasonable and necessary
- Transition to HEP
- Excessive therapy services
- Unskilled services
- Documentation is missing
- Lack of physician approval

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continued

continued

Why are Claims Denied?

- Failure to return medical records within the 30 day limit
- Records were for wrong dates of service
- Records were for wrong service/modality
- Duplication of services
- Information required to make payment was missing
 - Modality minutes
 - Initial evaluation
 - Documentation does not support billing

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continued

Why are Claims Denied

- Information required to make payment was missing
 - Modalities billed not indicated in POC
 - More than one unit is billed for an untimed CPT code
 - Treatments do not correspond to CPT definition
 - Dates billed are not the dates charted
 - Patient's name not on every page

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continued

Examples of Non-Covered Services

- Expected restoration potential is insignificant in relation to the extent and duration of therapy
- General range of motion to maintain function
- Activities to provide diversion or general motivation
- A home exercise program taught at the end of the skilled program

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What Can You Do?

- Perform Medicare documentation and billing audits
- Ensure all billing/coding meets LCD guidelines
- Technical components (e.g., CCI edits, KX, G Codes)
- Ensure all documentation supports services billed – Tell the story
- Develop a system to verify all aspects of technical Medicare requirements and support data
- Administration to have a strong participation in Medicare & Medicaid practice oversight

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Thank You

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