Answers to the top six frequently asked questions about physical therapy services

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Outpatient therapy services are an Office of the Inspector General (OIG) focus area in 2011. In recent years the OIG discovered that some outpatient therapy claims by independent physical therapists were not reasonable, medically necessary, or properly documented.

The OIG is watching outpatient therapy services including physical, occupational, and speech therapy. In the 2011 OIG Work Plan, the OIG includes this note:

> **Questionable Billing for Medicare Outpatient Therapy Serv**ices We will review paid claims data for Medicare outpatient therapy services from 2009 and identify questionable billing patterns. We will identify counties with high utilization and compare utilization in these counties to national averages. We will also determine the extent to which billing characteristics in high?utilization counties, including questionable characteristics that may indicate fraud, differed from billing characteristics nationwide.
> *(OEI; 04?09?00540; expected issue date: FY [fiscal year] 2011; work in progress)*

Review the documentation requirements for outpatient therapy in the *Medicare Benefit Policy Manual*, Pub. No. 100?02, ch. 15, § 220.3.The manual also includes a chart that breaks down the bill type and setting. Make sure you review this information so you are using the correct set of codes and the proper bill type, especially if you work with more than one type of provider or setting.

Let's start physical therapy reporting off in the right direction in 2011 with the help from these six frequently asked questions:

1. Are the initial plan of care and a certification the same thing?

The initial plan of care may also be called an evaluation and can be considered the certification. A certified plan of care includes the type of therapy, frequency, how long the patient is expected to receive therapy services, and the reason (i.e., medical necessity) for the therapy.

2. Is an order required?

Yes. An order (i.e., a request or a referral) is required for physical therapy services. A Medicare patient cannot merely walk into a physical therapy practice off the street, ask for treatment and expect Medicare to pay for the treatment without an order from a physician or qualified nonphysician provider (NPP).

3. What is meant by certifying a plan of care?

Certifying a plan of care is the plan of care that has been approved, dated, and signed (certified) by a physician or NPP. Medicare does not permit the therapist to certify the plan of care. Certification of the plan of care is a requirement of Medicare when reporting physical therapy services.

4. How often does a physician need to be involved with the patient after he or she orders and certifies physical therapy services, and the patient has begun the these services?

The physician should be involved with the patient if a new or major problem arises. The physician should also be involved when a significant change occurs in the patient's condition and he or she needs to significantly alter treatment. A new plan may be necessary and the physician or NPP would need to provide a recertification.

A recertification may also be needed if the physical therapy is helping the patient's circumstance and the therapist determines that continued therapy would be beneficial to the patient's condition. There is a time-limit for certified plans of care, usually within a 90-day time frame; therefore recertification is deemed necessary per Medicare.

5. What is meant by the term "qualified professional"?

A qualified professional is a physical therapist, occupational therapist, physician, nurse practitioner, clinical nurse specialist, or physician assistant who is licensed or certified by the state to perform therapy services, and who may appropriately perform therapy services under Medicare policies, according to Chapter 15 of the *Medicare Benefit Policy Manual*.

6. Bonus question: Does Medicare allow reimbursement when an athletic trainer performs a physical therapy service incident-to a physician/NPP?

CMS does *not* allow the reporting of incident to physical therapy services performed by an athletic trainer.

Always therapy codes Some CPT® and HCPCS therapy codes are considered "always therapy" codes, regardless of what type of provider performs the service. These services must always be an integral component of a rehabilitation plan of care. When billing for these services, include the therapy modifiers:

- -GN: Services delivered under an outpatient speech-language pathology plan
- -GO: Services delivered under an outpatient occupational therapy plan of care
- -GP: Services delivered under an outpatient physical therapy plan of care

Sometimes therapy codes Other CPT and HCPCS codes are "sometimes therapy" codes. The billing requirements for the codes in this group differ depending on the professional that provides the service and/or the circumstances under which the service is delivered.

- Any service in this code group that a qualified rehabilitation therapist provides is considered to be an "always therapy" service and must be delivered under a plan of care and billed with the appropriate therapy modifier.

- Bill any service in this code group that is provided as an integral part of a therapy plan of care with a therapy modifier regardless of the providing professional's credentials (e.g., physicians, NPPs, psychologists).
- Do not bill any service in this code group that is not appropriately part of a therapy plan of care and is provided by a non-therapist (e.g., physician, NPP, psychologist, or therapist working incident-to the physician/NPP) with the therapy modifier.

Check other payer policies
Remember to check with your local Medicare carrier, as local policies vary and some terms will differ.

Third-party carriers have their own policies. Check with each party contracted with your practice to ensure appropriate reporting and reimbursement. For example, the worker's compensation carrier in Michigan allows only 30 days of therapy and then requires a recertification, as opposed to Medicare, which allows 90 days.

Consider your state's scope of practice for outpatient rehabilitation when trying to understand physical therapy guidelines. You should also review the Stark Laws.

Editor's note: Bolarakis is a coding and compliance consultant for Navigant Consulting (formerly EthosPartners). She performs audits and offers physician education and answers to reimbursement questions. She also answers coding questions for clients and teaches coding classes as a PMCC instructor. E-mail your questions to Senior Managing Editor Michelle A. Lepert, CPC-A, at mleppert@hcpro.com.