

Therapy billing for beginners

By Sarah Wiskerchen, MBA, CPC

How to bill for physical, occupational therapy

Orthopaedic surgeons are increasingly incorporating physical and occupational therapy services into their practices. In-house billers, who may be inexperienced with the new services, terminology, and associated CPT codes, may be apprehensive about the move. Clarifying the services, codes, and treatment continuum will help to maximize revenue and prevent billing errors.

Understanding therapy CPT codes

As a first step in staff training, ask a therapist to lead a tutorial in evaluation and treatment protocols and modality terms, ideally in the therapy space, where staff can see the tools and equipment used. Before the tutorial, review the following physical and occupational therapy service categories in CPT:

- Evaluations and re-evaluations—Evaluations include assessment and documentation of the patient’s history, level of function, systems review, specific tests and measures, diagnosis, and prognosis. Unique evaluation and re-evaluation codes are used for physical therapists (CPT codes 97001 and 97002) and occupational therapists (CPT codes 97003 and 97004).
- Modalities—CPT defines supervised and constant attendance modalities as “any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.”
Some modalities, such as traction, unattended electrical stimulation, and whirlpool treatment, are “supervised” by the therapy provider, but don’t require one-on-one contact during modality delivery. As defined by CPT, supervised modalities are not timed services (CPT codes 97010–97028).
Other modalities, including manual electrical stimulation, ultrasound, and iontophoresis (using an electrical charge to deliver medication to inflamed tissue), are defined as “constant attendance” services that require one-on-one contact with the provider. These codes (CPT codes 97032–97039) are timed and billable in 15-minute increments.
- Therapeutic procedures (CPT codes 97110–97546)—These services are also timed and

require direct, one-on-one patient contact. Examples include therapeutic exercises and activities, neuromuscular re-education, aquatic therapy, gait training, and manual therapy. Therapeutic exercises and activities typically involve the use of gym-style equipment, stairs, or therabands.

- Active wound care management (CPT codes 97597–97606)—Wound care services promote healing by removing devitalized and necrotic tissue from the patient’s body. The provider has direct contact with the patient, and codes are determined by the type of débridement and wound surface size.
- Tests and measurements (CPT codes 97750–97755)—Although tests and measurements are a component of evaluation and re-evaluation, employers or insurance carriers may request specialized testing or assessment, which are reported using these codes.
- Orthotic and prosthetic management (CPT codes 97760–97762)—Therapists may provide specialized training in the use of orthotics and prosthetics, which is reported as a unique service.



The therapy episode

Understanding the following boldface terms and the chronology of therapy care is key to appropriate billing. Medicare coverage guidelines, which are often used by other payers as well, are outlined in Chapter 15, section 220, of the *Medicare Benefit Policy Manual* (publication 100-02). Although Medicare allows qualified nonphysician providers to order and certify therapy services, this focus is on physicians as the ordering entities.

Therapy **treatment** begins with a physician **order** or **referral**, which includes a diagnosis and may include directions for the type, duration, and intervals of treatment.

As a first step, the therapist performs an **evaluation** to define a **plan of care**, which builds on the physician’s order and details the patient’s long-term treatment goals and the therapy services planned. Re-evaluation may be needed when the plan of care or patient’s status

changes and may be reportable using a re-evaluation code. Medicare has a CCI edit between re-evaluation and several modalities and therapeutic procedures and requires the use of modifier -59 when both services are supported and documented.

Medicare guidelines call for the ordering physician to approve, or certify, the plan of care via signature in a timely manner (within 30 days of the evaluation). The **initial certification** covers 90 days or less of treatment, after which the plan of care must be recertified.

When setting up therapy services, practices should ensure the certification process works properly. Don't rely on your electronic medical record (EMR) system to relay the plan of care to the physician for certification without testing it first.

Treatment may begin on the day the plan of care is set. The treatment notes describe the patient's care at each visit (eg, modalities and therapeutic procedures). Documentation should include an assessment of improvement, modifications to the patient's goals, and both timed code minutes and total time with the patient. Interventions and modalities should be documented in terms that correspond with billing codes.

Medicare requires that the therapist provide a **progress report** for the ordering provider after the 10th treatment encounter, or within 30 calendar days of the first treatment, whichever is less. The therapist may include elements of the progress report within the treatment notes or a revised plan of care.

At the conclusion of the therapy episode, the therapist will prepare a **discharge note** that details the patient's treatment and status since the last progress note. Writing the progress report and discharge note are not separately billable services for the therapist, but are required for Medicare documentation.

Selected therapy services may be performed by a therapy assistant under the supervision of a therapist. Review your state guidelines and the *Medicare Benefit Policy Manual* for additional information.

Reporting timed services

Practices typically rely on the therapist or assistant to document required time elements within a progress note or EMR system. Billing staff may use the documentation to confirm the number of service units reported.

The Medicare guidelines for reporting timed services are detailed in Chapter 5, section 20.2, of the *Medicare Claims Processing Manual* (publication 100-04). Non-Medicare payers may also adhere to these time guidelines. Offices should confirm payer-specific requirements during contracting.

Providers should not bill for services performed for less than 8 minutes when only one service is administered in a day. Time intervals are assigned in increments of 15 minutes, beginning with a base of at least 8 minutes (1 unit is ≥ 8 –22 minutes; 2 units are ≥ 23 –37 minutes; 3 units

are \geq 38–52 minutes, etc). When more than one service represented by 15-minute timed codes is performed in a single day, the total minutes of service determines the number of timed units billed.

For example, a therapist provides 24 minutes of neuromuscular education and 23 minutes of therapeutic exercise yields a total of 47 minutes, or 3 units. The provider would report 2 units of neuromuscular re-education (the more lengthy service), and 1 unit of therapeutic exercises.

Some managed care plans limit payment to a defined number of services or modalities per visit, regardless of what was performed and billed. Billing staff need to be advised of such contract terms to support accurate appeals.

Medical necessity and LCD policies

Medical necessity is an essential element of therapy services. Medicare carriers may establish unique local carrier determination (LCD) policies for medical necessity that affect reimbursement. Refer to your carrier's Web site for LCD policy information.

In 2006, a cap on outpatient therapy services was put into effect; since then, legislative acts have provided methods for cap exceptions. In 2010, the Medicare cap for physical therapy is \$1,860. Medically necessary services that exceed that amount must use the modifier "-KX." The therapy department should track Medicare patient visits to ensure the modifier is appropriately applied. Many groups use an "allowable rate per visit" to determine when the cap is close to being met.

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