

Outpatient Therapy Guidelines Questions and Answers

(From the 11/28/07 and 11/29/07 Mediasite Presentations)

1. **We have an electronic medical record. We send our Plan of Care (POC) to physicians, and they electronically sign off on our notes. Is this acceptable?**

Answer: We will accept an electronic signature from the physician on the POC.

2. **Can you bill another evaluation for a new diagnosis in the same calendar year? What if the patient returns after being discharged for the same condition? Is this an evaluation or a re-evaluation?**

Answer: A new evaluation is appropriate whenever a new episode of treatment begins. If the patient needs treatment twice in the same calendar year, the new episode warrants a new evaluation, POC, etc. An evaluation is appropriate rather than a reevaluation since it is a separate episode.

3. **Is there a change recently or for next year? I have one from December 2007.**

Answer: As of 1/8/08, the only recent Change Request (CR) for therapy is the 2008 Annual Update to the Therapy Code List, CR 5810, Transmittal R1377CP dated 11/23/2007.

4. **Is it okay for the patient to have Electrical Stimulation Therapy (unattended) at the office if it is not appropriate for them to do it at home (e.g. for pain or edema)?**

Answer: The PHYSMED-009 policy states the following regarding coverage for Electrical Stimulation Therapy (unattended):

“One or two office treatments may be medically necessary to determine the effectiveness of treatment and for patient education in use of the home equipment. This device is covered for home use by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) and is governed under their jurisdiction.”

If you feel that additional services within the office are necessary, the services would deny initially, and you would need to ask for a redetermination with supporting documentation for review.

5. **Do certifications and re-certifications have to be chronological? In other words, no gaps in the time (e.g. certification covers from 11/20 through 12/20, does recertification begin on 12/21 or at the next patient visit)?**

Answer: Certifications and re-certification should be chronological with no gaps in time. According to the PHYSMED-001 policy:

“Certification is the physician’s/Non-Physician Practitioner’s (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. A certification interval is 30 calendar days or one month, whichever is longer.”

6. Where is the best place to find complete guidelines for both facility requirements and documentation/billing for private practice P.T.?

Answer: There are a number of available policies and procedures for the billing requirements for both facility and private practice therapy submission. In order to bill for Medicare Outpatient (Part B) services, it is necessary to research all applicable Physical Medicine polices as well as any additional applicable policies located on the WPS Medicare Website.

The PHYSMED-009 policy provides a section specific for private practice settings as well as a definition of a private practice facility.

The Centers for Medicare & Medicaid Services (CMS) Website has a number of different resources including the National Correct Coding Initiative (NCCI) and the Physician Fee Schedule (PFS) Relative Value File. The NCCI files are located at:
http://www.cms.hhs.gov/NationalCorrectCodiNitEd/01_overview.asp

The PFS Relative Value File is at:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage>

It is also important to view the CMS Website for any applicable Internet-only Manuals (IOM). You may access the IOM at the following CMS Website:

<http://www.cms.hhs.gov/Manuals/iom/list.asp>

Note: Please check with your current Medicare Part A fiscal intermediary (FI) if you need to submit any Medicare Part A (inpatient) physical medicine services.

7. If a new therapist at the facility is waiting for a Medicare provider number associated with that facility, can they treat the Medicare patients if a physical therapist is on site with a Medicare number?

Answer: If you are certain that the PT qualifies for a Medicare number, he or she could see Medicare Patients. The application does indicate 'date you first saw a Medicare Patient' so that the PT's new number could be valid from the first time he or she saw a Medicare patient. However, if you are not certain that the provider meets the requirements, the PT should not see a Medicare Patient until the number has been issued. The new PT cannot bill under the Medicare number of a different therapist on site. He or she should not bill until his or her own number is issued.

8. When documenting, do you have to specifically enter times for each code billed or can you bundle treatment time together?

Answer: As a follow-up to this question, it is not required that you separate and document the time for each code; however, the more complete and specific your documentation is, the easier and better it will be for the provider and the payer.