TO: ALL PROVIDERS

FROM: CAREFIRST OF MARYLAND INC., MEDICARE PART A

DATE: FEBRUARY 7, 2005

SUBJECT: DOCUMENTATION AND COVERAGE REQUIREMENTS FOR OUTPATIENT REHABILITATION SERVICES – REVISED

Note: This revision pertains to outpatient rehabilitation services as they relate to Non-Physician Practitioners. CMS Pub 100-2 CH 15 § 220 and 42 CFR § 424.24(c)(3) state that if a physician or Non-Physician Practitioner (NPP) establishes the plan of care, he/she must also certify the plan of care. If the plan of care is established by a physical or occupational therapist or speech language pathologist, a physician or NPP who has knowledge of the case must sign the plan of care.

Based on the analysis of data and the post-payment review of medical records, it has become apparent that CareFirst of MD, Inc., Medicare Part A needs to clarify the Centers for Medicare & Medicaid Services (CMS) instructions for physical therapy and occupational therapy documentation. The most prevalent problems identified relate to the following issues:

- In order to determine if the appropriate number of units per timed code was billed, the therapist should document the total time or the beginning and ending time for each session defined by a timed code. These times, as well as a description of each modality that was provided, are expected to be recorded in each patient's medical record. The amount of time spent on each modality should clearly support the number of units billed for each modality with regards to both timed and untimed HCPCS codes. A therapy evaluation or re-evaluation is not defined by a specific time frame; therefore, only one unit may be billed regardless of the amount of time spent delivering the service.

- To be covered, therapy services must be furnished to an individual who is under the care of a physician or NPP who certifies that the patient's therapy services are reasonable and necessary to the treatment of the individual's illness or injury. A written plan of treatment is required and if established by the therapist must be reviewed and date signed by the physician or NPP.

- When outpatient therapy services are continued under the same plan of treatment for a period of time, the physician or NPP must re-certify at intervals of at least once every 30 days from the date last seen by the referring physician or NPP that there is a continuing need for such services and estimate how long services are needed.

Therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time. Where an individual's improvement potential is insignificant in relation to the extent and duration of therapy services required to achieve improvement, such services would not be considered reasonable and necessary and thus are not covered.

While the services of a therapist in designing a maintenance program and making infrequent but periodic evaluations of its effectiveness would be covered, the program itself is not considered reasonable and necessary for the treatment of illness or injury and such services are not covered. The establishment of a safe and effective maintenance program for the management of lymphedema is an example of this sort of Program.

- The most appropriate HCPCS codes for the actual services provided need to be billed. Examples of HCPCS that have frequently been billed inappropriately include 97112 and 97530. Documentation in the medical record needs to support the specific HCPCS codes that are billed.

- The type, frequency, and duration of therapy services must be medically reasonable and necessary for the patient's condition under accepted medical, physical therapy, and occupational therapy practice standards. The ICD-9 diagnosis code (s) submitted on the claim must be representative of the patient's condition and supported in the medical record. The diagnosis on the claim should match the medical record.

  Note: When physical medicine and rehabilitation services are performed for patients who have suffered musculoskeletal or neurological complications secondary to some other disease, the ICD-9-CM diagnosis code reflecting the reason for the encounter should be listed first as the main reason for the service. Additional ICD-9-CM diagnosis codes that describe any current coexisting conditions are then listed as secondary diagnoses. For example:

  - Use the ICD-9-CM diagnosis code for contractures as the "first-listed diagnosis" (718.4) when they are the complications of Parkinson's disease (332.0) which should be listed second to indicate that the underlying condition is present; and ,
  - For aftercare of corrective surgery for deformities, use the appropriate V codes for surgical aftercare as the "first-listed diagnosis" (V54.13), not the diagnosis codes for the congenital or acquired deformity (820.9) which should be listed secondarily to describe the resolving condition.

- Medical Review has noted an increased number of therapy claims submitted with very poor documentation to support the services billed. This is resulting in denials of therapy services due to the inability to determine if the billed services are reasonable and necessary per Medicare guidelines. The following is an educational summary regarding the errors that are common to many providers:

    - Documentation needs to support that the services provided were at a skilled level of care. The medical record should clearly indicate the necessity and the role of the skilled clinician in the provision of the services.
    - It is important to include information to demonstrate that a change in the patient's condition has recently occurred. The medical necessity of the services provided needs to be clearly and consistently supported by the documentation in the medical record.
    - All signatures in the medical record need to be signed AND dated by the individual making the entry.
    - During the process of reviewing Skilled Nursing Facility (SNF) claims, we have seen that Plans of Treatment for therapy services are not always signed AND dated by the physician or NPP as required by CMS.
    - Within the necessary documentation listed below, the reason for the referral should be evident. A review of the information provided should:
        - Provide the reason for the referral as it relates to the primary or treating diagnosis (e.g., new injury, additional complications)
        - For chronic conditions, describe the specific changes in function that now necessitate that skilled therapy should be provided. (Simply stating “decline in function” by itself, does not adequately justify the initiation of therapy services)
    - The necessary documentation for therapy services should include the following:

        - Physician Orders

            - Modality or type of care to be furnished
            - Duration and frequency of service
            - Signed and dated by physician or NPP

- Plan of Treatment (Initial and current plan of care signed AND dated by the physician or NPP)

    - Diagnoses
        - Indicate the primary diagnosis for which therapy services are furnished.
        - Include the therapy diagnosis if different from the medical diagnosis (e.g., the medical diagnosis might be: "rheumatoid arthritis." However, if the shoulder is the only area being treated, the therapy diagnosis might be "adhesive capsulitis." Results of diagnostic tests used in making the diagnosis should be referenced.
        - List any other medical or therapy diagnoses that may influence care.

    - Type and nature of care to be furnished
    - Functional goals and estimated rehabilitation potential
    - Treatment objectives
    - Frequency of visit
    - Estimated duration of treatment
    - Signed and dated by physician or NPP

- Physician Certification and/or Re-certifications (Certification is obtained at the time the plan of treatment is established)

    - The services are or were furnished while the patient was under care of a physician or NPP
    - A plan for furnishing such services is or was established by the physician, NPP, or therapist and periodically reviewed by the physician or NPP
    - Services are or were required by the patient
    - Signed and dated by physician or NPP

- Evaluations and/or Re-evaluations

    - Functional goals and or disabilities
    - Patient baseline and goals
    - Discharge planning
    - Frequency, duration, type of treatment
    - Short term and long term goals

- Progress Notes (Treatment Summary for Billing Period)

  - Treatment time
  - Specific treatment modalities or procedures used
  - Therapist's skilled assessment of the patient's response to the treatment
  - Progress, if any, toward the goals
  - Problems, if any, interfering with progress
  - Any significant change in the patient's condition

Providers of therapy services need to keep in mind the following points when submitting therapy claims for review:

Initial Evaluations

The initial evaluation is the baseline for assessing the patient's deficits. If therapy is to be initiated, the expected rehabilitation potential must be determined and goals set. The treatment modalities and procedures for achieving the goals are established along with their frequency and duration.

The documentation that is being received is lacking in the following ways:

- There is no history submitted on the patient which explains the date of onset of the condition. This is especially true in regard to chronic conditions; that is, there is no documentation to reflect the recent change in the patient's condition which would warrant a therapy evaluation at the specified time. (Screening for therapy services is not a covered Medicare benefit.)

- The patient's most recent prior functional level is not stated in measurable, functional terms. This impedes setting realistic goals for each patient.

- Initial evaluations do not provide objective (where possible), measurable documentation of the patient's range of motion (ROM), strength, pain, mobility status or how any noted deficits affect activities of daily living (ADL) and functional abilities. Short term and long term goals need to be written in measurable, functional terms with a predicted date for achieving those goals. Strength, ROM and pain by themselves are not functional but can affect the patient's ability to function. For example, what is the patient unable to do because of his leg weakness? Will the increased strength allow ambulation with a lesser assistive device, less assistance, or advance to uneven surfaces or stairs? Without the tie to function, there will be a poor correlation between the goals written and the plan of care established.

Progress Notes

Specific information can help justify continued therapy. Completion of a checklist showing only which treatments were used does not meet this requirement. A checklist should be supplemented by a brief narrative including the above components to minimize possible denials of treatments as not reasonable and necessary.

Monthly summaries should:

- Refer back to the previous month's treatment;
- Show objective comparisons reflecting the patient's progress, or lack thereof, toward the established goals;
- Show clinical decision making related to continuing or discontinuing services;
- Address modification of goals;
- Show functional application of goals related to pain, strength and ROM.

Therapy Modalities

Specific documentation deficits have been noted in the following areas:

1. Therapeutic Exercise

   Therapeutic exercise is a covered Medicare service when the documentation reflects that the skills of the therapist are necessary to deliver the service. This is either due to the complexity of the exercise itself or due to the condition of the patient that the exercise can only be safely carried out by a skilled therapy professional.

   The type of exercise being utilized needs to be documented in the patient's record. The patient's response to the exercise program, and any progress towards developing a maintenance program for the beneficiary to follow once discharged, must also be documented.

   Therapeutic exercise, as part of the plan of care, must be more than just routine, repetitive exercise or general conditioning. Skilled exercise must be related to objective, measurable, functional goals.

2. Ultrasound and Electrical Stimulation

   If these, or any other treatments, are added to an ongoing plan of care, the documentation needs to support why these services are necessary for the patient's condition. To introduce a treatment without clear clinical rationale would not be considered reasonable or necessary.

3. Multiple modalities

Many modalities are being utilized simultaneously without documentation as to what benefit is expected. Specific treatments should be discontinued as they become no longer necessary. As the patient progresses, the therapist's skilled assessment of the patient's response as treatments are withdrawn allows the therapist to modify the patient's plan of care, established goals, or maintenance program.

4. Home exercise programs

The process of developing a home exercise program should begin with the initial evaluation. A maintenance program should be modified during the course of therapy, based on the patient's feedback to the clinician. To wait until the patient is ready for discharge is not in the patient's best interest. Furthermore, to continue therapy services solely to develop a maintenance program, after the goals have been met, would not be reasonable or necessary.

If you have any questions you can contact our Provider Service line at 1-866-488-0545.