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Coding *and* Payment Guide for the Physical Therapist

An essential coding, billing, and reimbursement resourcefor the physical therapist

2009

Contents

Introduction **1**
- Coding Systems 1
- ICD-9-CM Codes 1
- HCPCS Level I or CPT Codes 1
- HCPCS Level II Codes 2
- Claim Forms 2
- Contents and Format of This Guide 2
- Medicare Official Regulatory Information 2
- Index 3
- How to Use the Guide 3

The Reimbursement Process **5**
- Coverage Issues 5
- Payer Types 5
- Payment Methodologies 7
- Calculating Costs 9
- Other Factors Influencing Medicare Payment 9
- Participation in Medicare Plans 25
- Supplemental Medicare Coverage 26
- Medicare and Quality Reporting 30
- Workers' Compensation 31
- Collection Policies 31

Documentation—An Overview **33**
- General Guidelines for Documentation 33
- Guidelines: Physical Therapy Documentation of Patient/Client Management 35
- Fraud and Abuse 40

Claims Processing **43**
- What to Include on Claims 43
- Clean Claims 44
- Medicare Billing for Physical Therapists in Private Practice 44
- Processing the Claim 47
- The Appeals Process 48
- Benefit Notices 58
- CMS-1500 62
- Step-by-Step Claim Completion 63
- Electronic Claim Completion 72
- UB-04 84

Codes **89**

ICD-9-CM Index **161**
- ICD-9-CM Coding Conventions 161
- Coding Neoplasms 161
- Manifestation Codes 162
- Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital Based and Physician Office) 162
- ICD-9-CM Codes 163
- Alphabetic Index to External Causes of Injury and Poisoning (E Code) 266

Medicare Regulatory Information **305**

Glossary **325**

Correct Coding Initiative **337**

Index **339**

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The Reimbursement Process

Appropriate reimbursement for physical therapy services can sometimes be difficult because of the myriad of rules and paperwork involved. The following reimbursement guidelines help you understand the various requirements to get claims paid promptly and correctly.

Coverage Issues

First, you need to know which services are covered. Covered services are those payable by the insurer in accordance with the terms of the benefit-plan contract. Such services must be documented and medically necessary for payment to be made.

Typically, third-party payers define medically necessary services or supplies as:

- Services requiring the skills of a qualified provider
- Services established as safe and effective
- Services consistent with the symptoms or diagnosis
- Services necessary and consistent with generally accepted medical/professional standards
- Services furnished at the most appropriate, safe, and effective level

Documentation must be provided to support the medical necessity of a service, procedure, and/or other items. This documentation should show:

- What service or procedure was rendered
- To what extent the service or procedure was rendered
- Why the service, procedure, or other item was medically necessary

When providing physical therapy services, it is especially important for providers to thoroughly and individually document all care given to each patient at each visit, including the total treatment time and total direct contact time.

When in doubt, providers should consult with the specific payer or refer to Medicare national coverage determinations (NCD) or local coverage determinations (LCD). Local coverage determinations and national coverage determinations address the reasonable and necessary provisions of a service. LCDs include lists of conditions that support medical necessity, and often provide a corresponding ICD-9-CM code.

Verify that all services billed are medically necessary. If the provider feels that it is medically necessary for the patient to receive physical therapy interventions that are more or less than the current standard of practice, clearly document in the patient's record the rationale used for this decision. Physical and occupational therapy services are covered only for restorative therapy by Medicare, that is when there is the expectation to restore a patient's level of function that has been lost due to injury, disease, or illness, rather than to maintain a level of function. Maintenance care is not reimbursed by Medicare and many other third-party payers, but establishment and periodic reevaluation of a maintenance program is a covered service under Medicare.

Services, procedures, and/or other items that may not be considered medically necessary are:

- Services not furnished by a qualified provider
- Services that do not require the skills of a qualified provider
- Services not generally accepted as safe and effective for the condition being treated
- Services not proven to be safe and effective based on peer review or scientific literature
- Experimental or investigational services
- Services furnished at a duration, intensity, or frequency that is not medically appropriate
- Services not furnished in accordance with accepted standards of medical practice
- Services not furnished in a setting appropriate to the patient's medical needs and condition

Payer Types

Most providers have to deal with a number of different payers and plans, each with its own specific policies and methods of reimbursement. For that reason, it is important to become familiar with the guidelines for every payer and

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Documentation—An Overview

The role played by medical documentation has always been a supportive one. As the practice of medicine became more sophisticated and complex, the need to record specific clinical data has grown in importance. What certainly began as a simple written mechanism to jog the memory of a treating physician evolved into a more refined system to service others assisting in patient care. Tracking patient history emerged as a fundamental element in planning a course of treatment. When medical specialties evolved early in the last century, the patient record offered a means to provide pertinent data for referrals and consultations.

Still, until about 35 years ago, no clear standards existed for recording patient information. Medical documentation was seen, maintained, and used almost exclusively by physicians and medical staff. Patient care information was never submitted to insurance companies nor to government payers; only rarely did medical documentation become the focus of malpractice suits.

Marked changes to the Medicare program served to broaden the influence for medical documentation during the 1970s. For example, the Centers for Medicare and Medicaid Services (CMS), Medicare's federal administrator, authorized the program's regional carriers to review paid claims to determine whether the care was medically necessary, as mandated under the Social Security Act of 1996.

This type of review compares processed and paid claims against the documentation recorded at the time of service. The aim is to ensure that Medicare dollars are administered correctly and, once again, medical documentation must support the medical necessity of the service, to what extent the service was rendered, and why it was medically justified. For example, a physical therapist re-evaluates a patient after the prescribed treatment plan has been completed. The physical therapist determines that the patient would continue to benefit from further encounters for manual traction and therapeutic exercise. Depending upon the payer guidelines, this may require prior authorization from the primary care physician, or the payer.

Medicare does not pay for services that are "medically unnecessary" according to Medicare standards. Patients are not liable to pay for such services if the service is performed without prior notification from the physician. Medical necessity requires items and services to be:

- Consistent with symptoms or diagnosis of disease or injury
- Necessary and consistent with generally accepted professional medical standards (e.g., not experimental or investigational)
- Furnished at the most appropriate level that can be provided safely and effectively to the patient

Computer conversion of the review process has added a new twist: speed and a higher degree of accuracy. Claims adjudication, data analysis, and physician profiling revealed incongruities. A significant number of physicians and hospitals were found to have billed for services that were not provided or found to be medically unnecessary. Projected total estimates in the millions of dollars were publicized by CMS as findings of fraud and abuse. These findings led to the creation of the federal fraud and abuse program coordinated by several federal organizations, including the Department of Health and Human Services (HHS) and its agencies, CMS, and the Office of Inspector General (OIG).

Commercial insurance companies were quick to follow suit. Similar to CMS, private payers monitor claims to uncover coding mistakes and to verify that the documentation supports the claims submitted. Although there are no national guidelines for proper documentation, the guidelines this chapter provides should ensure better quality of care and increase the chances of full and fair reimbursement.

General Guidelines for Documentation

Documentation is the recording of pertinent facts and observations about a patient's health history, including past and present illnesses, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient to:

- Enable a health care professional to plan and evaluate the patient's treatment

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29580

29580 Strapping; Unna boot

Explanation

The physician applies an Unna boot to the leg or foot of a patient. An Unna boot is typically used to treat or prevent venostasis dermatitis or ulcers of the lower leg or foot. It is also used to control postoperative edema like that resulting from an amputation. The physician prepares this semirigid dressing by first making a paste of zinc oxide, gelatin, and glycerin. This is applied to the skin of the leg. A spiral or figure eight bandage is wrapped evenly over the leg. Paste is reapplied and further bandages are applied in the same fashion until the desired rigidity is obtained. Elastic bandages are often added to the dressings for reinforcement. The dressing is typically replaced at least once a week or more often as needed.

Coding Tips

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system.

Terms to Know

edema. Swelling due to fluid accumulation in the intercellular spaces.

ICD-9 Diagnostic Codes

249.71 Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled

249.80 Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified

250.70 Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled

250.71 Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled

250.73 Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled

250.81 Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled

454.8 Varicose veins of the lower extremities with other complications

459.10 Postphlebitic syndrome without complications

459.11 Postphlebitic syndrome with ulcer

459.12 Postphlebitic syndrome with inflammation

459.33 Chronic venous hypertension with ulcer and inflammation

459.81 Unspecified venous (peripheral) insufficiency

682.7 Cellulitis and abscess of foot, except toes

707.13 Ulcer of ankle

707.14 Ulcer of heel and midfoot

707.15 Ulcer of other part of foot

728.71 Plantar fascial fibromatosis

891.1 Open wound of knee, leg (except thigh), and ankle, complicated

IOM References

100-3,270.5; 100-4,3,20.1.2.8; 100-4,12,30

CCI Version 14.3

15852, 29540-29550, 29700, 36000, 36410, 37202, 51701-51703, 62318-62319, 64415-64417, 64470, 64475, 69990, 87070, 87076-87077, 90760, 90765, 90772, 90774, 90775

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

	Work Value	Non-Fac PE	Fac PE	Malprctice	Non-Fac Total	Fac Total
29580	0.55	0.69	0.34	0.07	1.31	0.96

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