Outpatient Therapy & Rehabilitation Provider Compliance Summary

Documentation Compliance Criteria for Physicians, NPPs, Physical, Occupational and Speech Therapists

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Purpose

The United Mine Workers of America Health and Retirement Funds (the Funds) processes and pays Medicare claims as a Health Care Prepayment Plan contracted through the Centers for Medicare and Medicaid Services (CMS). The purpose of this summary is to provide education about Medicare documentation guidelines to improve the quality of records needed to support the payment of Medicare claims paid by the Funds on behalf of CMS.

Requirement & Retrospective Audits

Medicare requires documentation which is legible, complete, appropriately authenticated and supports medical necessity for services reported on the insurance claim form. You may be audited retrospectively by the Funds or CMS to ensure that you have complied with all Medicare payment policies.

Legibility of the Record

- Upon a request for records or for authorization purposes, if hand-written records are not legible, please also submit a typed or printed version of the record reflecting its contents word-for-word.
- All evaluations, progress notes, exercise logs and entries made in the patient's record should be legible, dated, time stamped and signed by the author and supervising therapist.
- The signature of the provider ordering therapy and signing the Plan of Care should be legible.
- Each note stands alone and should include sufficient information to support the level of service, medical necessity and codes reported on the claim form.
- Generally, the medical record should not be altered. However, errors should be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions should be dated, timed, and legibly signed or initialed. You should not add signatures at a later date or alter the record in any way not permitted by applicable Medicare requirements. Delayed entries within a reasonable time frame (24-48 hrs.) may be acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- Medicare generally requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature (stamp signatures are not acceptable). Please see additional directives provided below under "Authentication of Records, Orders, and Notes."

- To avoid an error for signature reasons, we recommend that you make certain your documentation contains a LEGIBLE IDENTIFIER (signature) or valid electronic signature of the *person performing the service* and include a signature sample when responding to a request for records.
- The authentication requirement (i.e., legible signature, signature log or signature attestation statement) applies to various documents for Medicare-covered services. The Funds follows applicable Medicare authentication guidelines.

Authentication of Records, Orders, and Notes

The Funds recommends the following to properly authenticate your documents related to Medicare claims:

- ALWAYS sign your notes and document and sign all entries. Notes and/or entries submitted with just a typed signature/signature line with no handwritten or electronic signature may not be acceptable.
- Notes that have been transcribed should always be reviewed and signed – either electronically or with a hand-written signature - by the author of the note.
- Do not sign a typed note without proof reading and making corrections to the note prior to signing.
- You should print your name along with your written signature for clarification.
- Initials should also have a printed name for clarification.
- Signatures should be legible. A signature for which no letters can be established or that does not contain a typed/printed name for clarification is not acceptable. Signature logs should be submitted when the signature is not legible. Signature logs should contain a sample signature with a typed or printed name, credentials (PT, OT, SLP, PTA, etc.), and when employment began and terminated (if applicable). Please use the sample signature log accompanying this summary.
- When a signature is not present and the record has been requested for review or audit by the Funds, please use the attached Medicare attestation statement. Provide the appropriate information on the attestation statement, sign it (legibly), and submit the attestation statement with the unsigned records to the Funds. The attestation statement should be signed by the supervising therapist on record for the claim under review.

The following are acceptable forms of signature for Medicare claims:

- Legible handwritten signatures
- Illegible signatures over a typed/printed name
- Illegible signatures where the letterhead, addressograph or other information on the page indicates the identity of the individual signing the document
- Illegible signatures accompanied by a signature log or an attestation statement
- A legible first initial and last name

- Initials over a typed/printed name or accompanied by a signature log or an attestation statement

Coding Guidelines

Claims should be coded using data sets in accordance with the applicable Administrative Simplification Rules of the Health Insurance Portability & Accountability Act of 1996, as amended (HIPAA). The current year Current Procedural Terminology (CPT), HCPCS level 1 and ICD-9-CM codes should be used when coding Medicare claims sent to the Funds. Applicable coding guidelines and applicable Medicare medical necessity guidelines found in your Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) should be followed. Applicable Medicare National Correct Coding Initiative (NCCI) bundling guidelines and applicable Medically Unlikely Edits (MUEs) should be used prior to filing a Medicare claim with the Funds.

Services of Physical Therapy Support Personnel

The Funds follows applicable Medicare guidelines regarding billable personnel providing therapy services. Personnel eligible for reimbursement of therapy claims may be any of the following:

- Physician
- Qualified therapists (PT, OT, and SLP)
- Therapy Assistants (except speech-language pathology) when working under the supervision of a qualified therapist. Private practice therapy clinics require direct supervision.

Not Payable under Medicare Part B

Services performed by students, aides, athletic trainers, exercise physiologists, massage therapists, recreation therapists, kinesiotherapists, low vision specialists, pilates instructors, rehabilitation technicians and life skills trainers are not payable under Medicare Part B even if performed under the supervision of a qualified therapist.

Students

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. The therapist's (or therapy assistant's) skilled time may be billable if the student participates in the delivery of the services when the therapist is present in the room and is directing the service, making skilled judgments, and is responsible for the assessment and treatment. The therapist may not be engaging in treating another patient or doing other tasks at the same time.

The therapist is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services.)

Initial Certification of the Plan of Care

The physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements for the duration of the plan of care, or ***90 calendar days*** from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan. Timely certification of the initial plan of care is met when the physician/NPP certification of the plan of care is documented, by signature or verbal order, and *dated within **30 days** following the first day of treatment* (including evaluation). Verbal orders must be followed within ***14 days by a signature and date***.

Recertification

Recertifications documenting the need for continued or modified therapy should be signed whenever the need for a significant modification of the plan of care becomes evident, or at ***least every 90 days*** after initiation of treatment under the plan of care, unless the recertifications are delayed. Recertification is required sooner when the duration of the plan of care is less than 90 days.

Initial Patient Documentation Standards

The initial evaluation should document the necessity of a course of therapy through objective findings and subjective patient self-reporting. In general, the initial evaluations shall include:

- A diagnosis (where allowed by state and local law) and description of the specific problem(s) to be evaluated and/or treated. Include all conditions and complexities that may impact the treatment;
- Documentation to indicate objective, measurable beneficiary physical function;
- Therapist's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement measurement tools; and
- A determination that treatment is not needed, or, if treatment is needed, a prognosis for return to premorbid condition or maximum expected condition with expected time frame and a plan of care.

The American Physical Therapy Association ("APTA")[1] recommends the following documentation for the initial evaluation:

History Documentation

- General demographics
- Social history
- Employment/work (Job/School/Play)
- Growth and development
- Living environment
- General health status (self-report, family report, caregiver report)
- Social/health habits (past and current)
- Family history
- Medical/surgical history

[1] APTA is not affiliated with CMS and does not set Medicare policy. The APTA recommendations are provided as a reference, but following APTA's guidance will not guarantee payment by the Medicare program.

- Current condition(s)/Chief complaint(s)
- Functional status and activity level
- Medications
- Other clinical tests

APTA recommends gathering the following data to document the physiologic and anatomical status:

Cardiovascular/pulmonary
- Blood pressure
- Edema
- Heart Rate
- Respiratory Rate

Integumentary:
- Pliability (texture)
- Presence of scar formation
- Skin color
- Skin integrity

Musculoskeletal:
- Gross range of motion
- Gross strength
- Gross symmetry
- Height
- Weight

Neuromuscular:
- Gross coordinated movement (eg, balance, locomotion, transfers, and transitions)
- Motor function (motor control, motor learning)
- A review of communication ability, affect, cognition, language, and learning style:
- Ability to make needs known
- Consciousness
- Orientation
- Expected emotional/behavioral responses
- Learning preferences
- Orientation (person, place, time)

Tests and Measures Documentation

APTA recommends the following list of tests and measures categories for which findings may be documented in the record of the examination and evaluation:

- Aerobic capacity/endurance. Examples of examination findings include:
  - Aerobic capacity during functional activities
  - Aerobic capacity during standardized exercise test protocols
  - Cardiovascular signs and symptoms in response to increased oxygen demand with exercise or activity
  - Pulmonary signs and symptoms in response to increased oxygen demand with exercise or activity
- Anthropometric characteristics. Examples of examination findings include:
  - Body composition
  - Body dimensions
  - Edema
- Arousal, attention, and cognition. Examples of examination findings include:
  - Arousal and attention
  - Cognition
  - Communication
  - Consciousness

- Motivation
- Orientation to time, person, place and situation
- Recall

- Assistive and adaptive devices. Examples of examination findings include:
  - Assistive or adaptive devices and equipment use during functional activities
  - Components, alignment, fit and ability to care for the assistive or adaptive devices and equipment
  - Remediation of impairments, activity limitations, and participation restrictions with use of assistive or adaptive devices and equipment
  - Safety during use of assistive or adaptive devices and equipment
- Circulation (arterial, venous, lymphatic). Examples of examination findings include:
  - Cardiovascular signs
  - Cardiovascular symptoms
  - Physiological responses to position change
- Cranial and peripheral nerve integrity. Examples of examination findings include:
  - Electrophysiological integrity
  - Motor distribution of the cranial nerves
  - Motor distribution of the peripheral nerves
  - Response to neural provocation
  - Response to stimuli, including auditory, gustatory, olfactory, pharyngeal, vestibular, and visual
  - Sensory distribution of the cranial nerves
  - Sensory distribution of the peripheral nerves
- Environmental, home, and work (job, school, play) barriers. Examples of examination findings include:
  - Current and potential barriers
  - Physical space and environment
- Ergonomics and body mechanics. Examples of examination findings for ergonomics include:
  - Dexterity and coordination during work
  - Functional capacity and performance during work actions, tasks, or activities
  - Safety in work environments
  - Specific work conditions or activities
  - Tools, devices, equipment, and work-stations related to work actions, tasks, or activities

  Examples of examination findings for body mechanics include:
  - Body mechanics during self-care, home management, work, community, or leisure actions, tasks, or activities
- Gait, locomotion, and balance. Examples of examination findings include:
  - Balance during functional activities with or without the use of assistive, adaptive, orthotic, protection, supportive, or prosthetic devices or equipment
  - Balance (dynamic and static) with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
  - Gait and locomotion during functional activities with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment

- Gait and locomotion with or without the use of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices or equipment
- Safety during gait, locomotion, and balance

➢ Integumentary integrity. Examples of examination findings include:
- Associated with skin:
    - Activities, positioning and postures that produce or relieve trauma to the skin
    - Assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that may produce or relieve trauma to the skin
    - Skin characteristics

Wound:
- ➢ Activities, positioning and postures that aggravate the wound or scar or that produce or relieve trauma
- Burn
- Signs of infection
- Wound characteristics
- Wound scar tissue characteristics

Joint Integrity and Mobility. Examples of examination findings include:
- Joint integrity and mobility
- Joint play movements
- Specific body parts

➢ Motor function. Examples of examination findings include:
- Dexterity, coordination, and agility
- Electrophysiological integrity
- Hand function
- Initiation, modification, and control of movement patterns and voluntary postures

➢ Muscle performance. Examples of examination findings include:
- Electrophysiological integrity
- Muscle strength, power, and endurance
- Muscle strength, power, and endurance during functional activities
- Muscle tension

➢ Neuromotor development and sensory integration. Examples of examination findings include:
- Acquisition and evolution of motor skills
- Oral motor function, phonation, and speech production
- Sensorimotor integration

➢ Orthotic, protective, and supportive devices. Examples of examination findings include:
- Components, alignment, fit, and ability to care for the orthotic, protective, and supportive devices and equipment
- Orthotic, protective, and supportive devices and equipment use during functional activities
- Remediation of impairments, activity limitations, and participation restrictions with use of orthotic, protective, and supportive devices and equipment
- Safety during use of orthotic, protective, and supportive devices and equipment

➢ Pain. Examples of examination findings include:
- Pain, soreness, and nocioception

- Pain in specific body parts

- Posture. Examples of examination findings include:
  - Postural alignment and position (dynamic)
  - Postural alignment and position (static)
  - Specific body parts

Prosthetic requirements. Examples of examination findings include:

- Components, alignment, fit, and ability to care for prosthetic device
- Prosthetic device use during functional activities
- Remediation of impairments, activity limitations, and participation restrictions with use of the prosthetic device
- Residual limb or adjacent segment
- Safety during use of the prosthetic device
- Range of motion (including muscle length). Examples of examination findings include:
  - Functional ROM
  - Joint active and passive movement
  - Muscle length, soft tissue extensibility, and flexibility
- Reflex integrity. Examples of examination findings include:
  - Deep reflexes
  - Electrophysiological integrity
  - Postural reflexes and reactions, including righting, equilibrium, and protective reactions
  - Primitive reflexes and reactions
  - Resistance to passive stretch
  - Superficial reflexes and reactions
- Self-care and home management. Examples of examination findings include:
  - Ability to gain access to home environments
  - Ability to perform self-care and home management activities with or without assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment
  - Safety in self-care and home management activities and environments
- Sensory integrity. Examples of examination findings include:
  - Combined/cortical sensations
  - Deep sensations
  - Electrophysiological integrity
- Ventilation and respiration. Examples of examination findings include:
  - Pulmonary signs of respiration/gas exchange
  - Pulmonary signs of ventilatory function
  - Pulmonary symptoms
- Work (job/school/play), community, and leisure integration or reintegration. Examples of examination findings include:
  - Ability to assume or resume work (job/school/play), community, and leisure activities with or without assistive, adaptive, orthotic, protective, supportive or prosthetic devices and equipment
  - Ability to gain access to work (job/school/play), community, and leisure environments
  - Safety in work (job/school/play), community, and leisure activities and environments

The Plan of Care (POC) or Plan of Treatment (POT)
Documentation should clearly indicate the need for skilled therapy (medical necessity).

Skilled Therapy: The deciding factor in determining if a therapy service is skilled is whether the skills of a therapist are needed to treat the illness or injury, or whether the service can be carried out by a non-skilled person. Other points in determining skilled therapy which should be recorded during the initial evaluation are:

- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist.
- Services that do not require the performance or supervision of a therapist, or therapy assistant under the supervision of a therapist even if they are performed or supervised by a qualified professional.
- Rehabilitative therapy occurs when the skills of a therapist are necessary to safely and effectively furnish a recognized therapy service, whose goal is improvement of an impairment or functional limitation.
- While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.

Changes to the Therapy Plan of Care or Treatment
While the physician (or non-physician practitioner (NPP)) may change a plan of treatment established by the therapist providing such services, *the therapist may not significantly alter a plan of treatment established or certified by a physician/NPP without their documented written or verbal approval*.

Documentation of the Continuation of Care
APTA recommends the following:

- Documentation for every visit/encounter.
- Authentication and appropriate designation of the physical therapist, or, under certain circumstances and when permissible by law, the physical therapist assistant providing the service under the direction and supervision of a physical therapist.
- Documentation of each visit/encounter should include the following elements:
  - Patient/client self-report (as appropriate)
  - Identification of specific interventions provided, including frequency, intensity, and duration as appropriate
    Examples include:
    - Knee extension, three sets, ten repetitions, 10# weight
    - Transfer training bed to chair with sliding board

- Equipment provided
- Changes in patient/client status as they relate to the plan of care
- Equipment provided:
    - Response to interventions, including adverse reactions, if any
    - Factors that modify frequency or intensity of intervention and progression goals, including patient/client adherence to patient/client-related instructions
    - Communication/consultation with providers/patient/client/family/significant other

Documentation of Reexamination & Progress Reports

APTA recommends documentation of reexamination provided as appropriate, to evaluate progress and to modify or redirect intervention. Documentation of reexamination should include the following elements:

- Documentation of selected components of examination to update patient's/client's functioning and/or disability status;
- Interpretation of findings and, when indicated, revision of goals;
- When indicated, revision of plan of care, as directly correlated with goals as documented; and
- Authentication by and appropriate designation of the physical therapist.

Documentation of Summation of Episode of Care

APTA recommends that documentation of discharge or discontinuation shall include the following elements:

- Current physical/functional status
- Degree of goals and outcomes achieved and reasons for goals and outcomes not being achieved

Discharge or discontinuation plan that includes written and verbal communication related to the patient's/client's continuing care. Examples include:

- Home program
- Referrals for additional services
- Recommendations for follow-up physical therapy care
- Family and caregiver training
- Equipment provided

Supporting Documentation of Time for Units of Service

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS 1450 were required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code.

Documentation for Untimed HCPCS codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

Documentation for Time-based CPT codes

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15 minute units of service. When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

For any single timed CPT code in the same day measured in 15 minutes units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes.
If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

3 units	≥	38 minutes through 52 minutes
4 units	≥	53 minutes through 67 minutes
5 units	≥	68 minutes through 82 minutes
6 units	≥	83 minutes through 97 minutes
7 units	≥	98 minutes through 112 minutes
8 units	≥	113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

If more than one timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is **constrained** by the total timed treatment minutes for that day according to Medicare guidelines.

- If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.
- When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted in the chart above) determines the number of timed units billed.
- If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed

for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

- The expectation (based on the work values for these codes) is that a ***provider's direct patient contact time for each unit will average 15 minutes in length***. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

Group Therapy Services

When outpatient therapy services (which includes outpatient physical therapy, occupational therapy and speech-language pathology services) are provided simultaneously to two or more individuals by a practitioner, it should be coded as group therapy services (97150).

The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

Recommended Medicare Resources & References (not all inclusive)

CMS Web Site for Therapy http://www.cms.gov/therapyservices/
Medicare Benefits Policy Manual, Chapter 15
American Physical Therapy Association (APTA) Documentation Guidelines
Section 1861 of the Social Security Act
Applicable Local Coverage Determinations and any current or future applicable National Coverage Determinations