PRS PHYSICIANS REHAB SOLUTION

Starting PT: The Building Blocks of Success

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Objectives

- Identify the key components of a PT/OT program that dictate success vs failure.
- Understand the key clinical metrics that are associated with a successful PT/OT program, and how to manage towards local, regional, and national benchmarking.
- Better understand the Revenue Cycle Process for a PT practice and how to effectively manage.

Key Components

1. **Regulatory Compliance**
2. **Recruitment/Training**
3. **Productivity and Quality of Care Balance**
4. **Revenue Cycle Management**

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Regulatory Compliance

- Stark Law
- CMS Guidelines- Medicare Benefits and Policy Manual Ch. 15 section 220
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- Physical and Occupational Therapy State Practice Regulations- http://www.scstatehouse.gov/code/t40c045.php
- Insurance-Specific Guidelines

Regulatory Compliance - CMS

Supervision Requirements:

- CMS
  - **General Supervision-** therapist is not required to be in the suite/building. General supervision of PTAs and support personnel is not acceptable for Medicare patients unless you have special clinic credentialing (i.e. Rehab Agency)
  - **Direct Supervision-** therapist must be in the suite but not necessarily in line of sight of the patient. CMS allows direct supervision of PTAs for purposes of billing. Any work performed by support personnel is non-billable per CMS.

Regulatory Compliance - CMS

Minimal documentation required for billing purposes (per CMS):

1. Evaluation and Plan of Care
2. Certification/Re-certification
3. Progress Reports
4. Treatment Notes

**State regulations/payer regulations may vary.*

Regulatory Compliance - CMS

Evaluation Minimal Requirements:

- Diagnosis
- Results of standardized outcomes tool (recommended, not required)- Medicare recognizes four: NOMS, FOTO, AM-PAC, OPTIMAL AND/OR:

Identification of other health services concurrently being provided	Factors that impact severity
Identification of DME needed	Documentation of supporting medical care provided prior to current episode
Identification of the # medication taken	Documentation indicating beneficiary health related to quality of life
Complicating factors affecting treatment	Documentation indicating beneficiary social support
Generalized or multiple conditions	Documentation indicating objective, measurable beneficiary physical function
Mental or cognitive disorder	

Regulatory Compliance - CMS

Evaluation Minimal Requirements (cont'd):

- Clinical judgment or subjective impressions that describe the current functional status.

- 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.

Regulatory Compliance - CMS

Certification/Re-certification Requirements:

- Diagnosis
- Long Term Goals
- Type, amount, duration and frequency of therapy services
- Physician dated signature
- Required at a minimum of every 90 days

Regulatory Compliance - CMS

Progress Reports Minimum Requirements:

- Due on every 10th treatment day
- Assessment of improvement, extent of progress towards each goal
- Plans for continuing treatment
- Changes to goals
- Functional Documentation

Regulatory Compliance - CMS

Treatment Notes Minimal Requirements:

- Date of treatment
- Identification of specific intervention/modality provided and billed
- Total Timed code treatment minutes
- Total treatment time in minutes
- Signature and professional identification
- Optional:

Pt self report	**Adverse reaction to treatment**
Communication w/ other providers	Significant, unusual or unexpected changes
Equipment provided	Other additional, relevant info

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Recruitment/Hiring/Training

Hire good people!

- The cost of a bad hire can equal 30% of the individual's first-year earning potential
- 37% of employers saw a negative impact on overall employee morale
- 43% of employers said the reason for the bad hires was to fill the position quickly
- 80% of employee turnover is a result of bad hiring

Recruitment / Hiring / Training

Recruitment Strategies:

- Network even when a position is not open- it is important to make the effort to speak to candidates who come recommended by people you trust.
- Make lists of traits you see in your successful employees- updating and reviewing this list can help you weed through candidates as you try to identify these traits in prospective new hires.
- Build some of your interview questions from typical day-to-day tasks- see how they react and how they would handle the task.
- Take note of communication patterns with prospective new hires- how timely do they respond? How do they express themselves? Take note and ensure that their level of interest and communication style is compatible with you.

Recruitment/Hiring/Training

- Get the team involved- this hire will affect the entire team. Draw team members in to the interview process. They may pick up on something that you missed and the collaboration will build team rapport.

- Check references- even though you know they are likely not going to give negative references be prepared to follow through and don't hesitate to ask the difficult questions you need answered.

- Be upfront with "leap of faith" candidates- perhaps a candidate seems good but you're concerned w/ their lack of experience. Let them know where you need them to show improvement.

Recruitment/Hiring/Training

Traits of an Ideal Therapist :

- They are proactive, not reactive
- They are passionate about what they do
- They express a desire for knowledge
- They demonstrate excellent organizational skills
- The demonstrate excellent multi-tasking ability

Recruitment/Hiring/Training

Comprehensive Orientation Program

- To successfully integrate your therapists into your culture and expectations you must have a robust, comprehensive orientation program

- This program should include (but not limited to):
  - Physician expectations/protocols
  - Quality of care expectations
  - Regulatory compliance
  - Productivity expectations
  - Revenue Cycle Management- billing, documentation, etc.
  - EMR training
  - Physician shadowing

Key Components

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Productivity – Quality of Care Balance (Visits)

Benchmarks:

- Evaluations per FTE: 2 - 4
- Visits per FTE: 10 - 12
- Visits per Day: # of FTE clinicians x 11
- Visits per Evaluation: 10

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Productivity – Quality of Care Balance (Units)

Benchmarks:

- Units per Visit: 4.00
- Units per FTE: 44.00
- RVUs per Visit: 1.66
- RVUs per FTE: 18.26

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Productivity – Quality of Care Balance (Quality)

Benchmarks:

- Cancellation Rate: <10%
- Functional Outcomes- varies by outcomes tool used; recommended that you utilize a standardized tool that tracks and compares your clinic's outcomes to the national average.
  - Care Connections
  - FOTO
  - Oswestry
  - Berg Balance Test
  - DGI
- Patient Satisfaction- again, scores vary dependent upon the questionnaire used but generally you should be shooting for a score >95% of the best result possible.

Key Components

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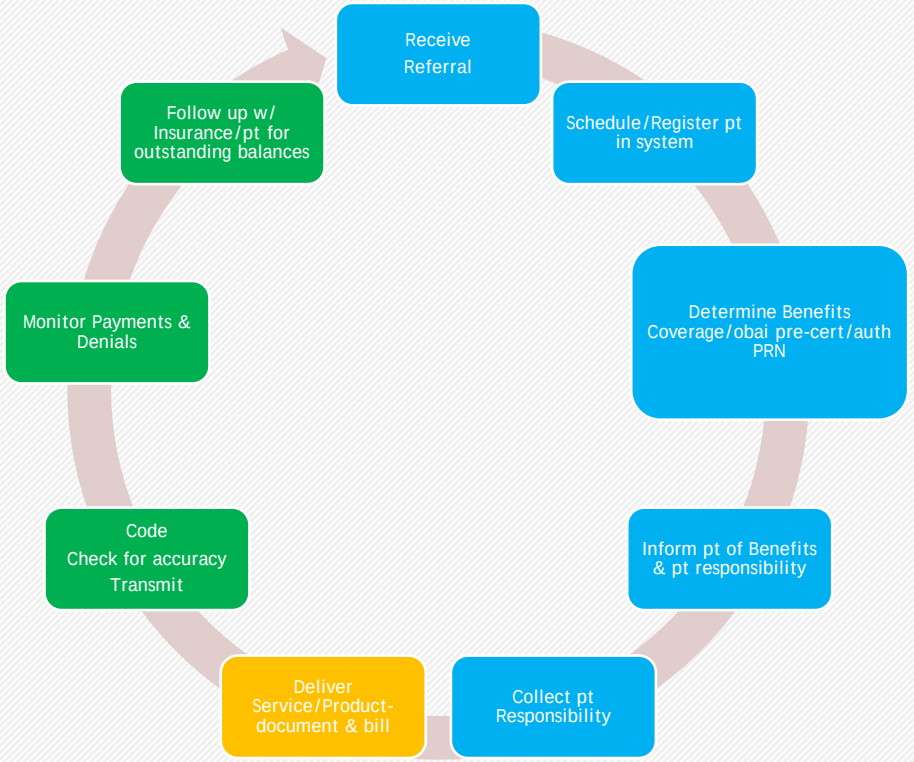
Revenue Cycle Management - The Cycle



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Revenue Cycle Management - Referrals

- **Inbound Referrals-** defined as the number of referrals written by your physicians/NPPs and received by your rehab dept (not necessarily captured)
- **Outbound Referrals-** defined as the number of referrals written by your physicians/NPPs and not scheduled/received by your rehab dept.
- **Outside Referrals-** defined as the number of referrals received by your rehab dept written by physician/NPPs not associated with your physician's practice.
- **Capture Rate (overall)-** defined as: Total Referrals / Total Evaluations
- **Capture Rate (Scheduled)-** defined as: Total Inbound Referrals / Total Evaluations; Benchmark = 95%

Revenue Cycle Management - Front End Processes

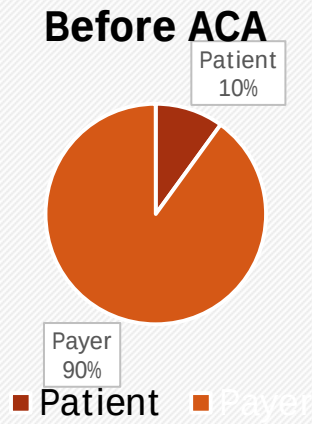
Scheduling Strategies:

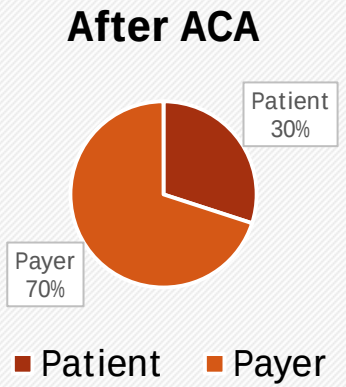
- Identify Visit Type- evaluations, re-evaluations, follow up visits, Medicare patients.
- Scheduling matrix-
  - Booking 60 min, 45 min or 30 min time slots
  - Medicare team
  - Staggered MC slots

- Cancellation Management- in terms of scheduling, you must factor in your cancellation rate when booking the therapists' schedules.

Revenue Cycle Management - Front End Processes

- Verify and review benefits and explain patient's financial responsibility
- Collect upfront collections- Benchmark = $15 - 25/visit dependent on payer mix





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Revenue Cycle Management- Delivery of Services/Products (Documentation)

Documentation:

Top 10 Tips for Defensible Documentation

1. Limit use of abbreviations.
2. Date and sign all entries.
3. Document legibly.
4. Report functional progress towards goals regularly.
5. Document at the time of the visit when possible.
6. Clearly identify note types (eg, progress reports, daily notes).
7. Include all related communications.
8. Include missed or cancelled visits.
9. Demonstrate skilled care and medical necessity.
10. Demonstrate planning throughout for the conclusion of the episode of care.

Revenue Cycle Management- Delivery of Services/Products

Billing Training

- Medicare's 8 minute Rule vs AMA's Substantial Portion Rule
- Timed vs Untimed codes
- Functional Limitation Reporting
- Supervision requirements
- CCI Edits
- Excluded codes

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Revenue Cycle Management- Delivery of Services/Products (8 min rule v Substantial Portion Rule)

Medicare's 8 minute Rule vs AMA's Substantial Portion Rule:

- Do not apply Medicare's 8 min rule to all payers!!
- What's the difference?
  - Total Treatment Time
    - CMS- required factor when determining units
    - AMA- not required factor, use substantial portion rule when determining factors
- Review your contracts for CMS verbiage

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Revenue Cycle Management- Delivery of Services/Products (8 min rule v Substantial Portion Rule)

UNITS OF SERVICE (Medicare 8 Minute Rule)		
8 - 22 minutes total for all time-based modalities	=	1 unit
23 - 37 minutes total for all time-based modalities	=	2 units
38 - 52 minutes total for all time-based modalities	=	3 units
53 - 67 minutes total for all time-based modalities	=	4 units
68 - 82 minutes total for all time-based modalities	=	5 units
83 minutes total for all time-based modalities	=	6 units

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Revenue Cycle Management- Delivery of Services/Products (8 min rule v Substantial Portion Rule)

Example:

- PT was seen for 32 min and received 12 min of ther ex, 10 min of ther. act and 10 min of manual therapy.
- What would you bill:
  - CMS?
  - Commercial payer?

Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

Untimed codes:

- Not timed based (unless specific payer policy states otherwise)
- Regardless of how many different body parts your therapist treated with the same modality/or how long the modality is used on the patient, therapist can only bill one unit of each un-timed service code daily.

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Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

PT Un-timed Evaluation Management Codes:

- 97161- Physical Therapy Evaluation Low Complexity
- 97162- Physical Therapy Evaluation Moderate Complexity
- 97163- Physical Therapy Evaluation High Complexity
- 97164- Physical Therapy Re-Evaluation

Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

OT Un-timed Evaluation Management Codes:

- 97165- Occupational Therapy Evaluation Low Complexity
- 97166- Occupational Therapy Evaluation Moderate Complexity
- 97167- Occupational Therapy Evaluation High Complexity
- 97168- Occupational Therapy Re-Evaluation

Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

Un-timed Supervised Modalities:

- 97010 - Application of a modality to one or more areas; hot or cold packs
- 97012 - Traction, mechanical (not manual)
- 97014 - Electrical Stimulation (unattended)(G0283 For Medicare)
- 97016 - Vasopneumatic Devices
- 97018 - Paraffin Bath
- 97022 - Whirlpool (May include fluidotherapy unless told otherwise by payer)
- 97024 – Diathermy Treatment
- 97026 – Infrared Treatment

Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

Time Based Codes:

- The application of a modality or procedure that requires direct (one-on-one) patient contact.
- Constant attendance involves visual, verbal, and/or manual contact with the patient during provision of the service.
- Are time-based, 15-minute increments codes. A unit of time is attained when the mid-point is passed. (AMA CPT Billing Guidelines: Page xii).
- Can bill multiple units of the same CPT code to the same patient on the same day if medically necessary and meets the time requirements for billing per the insurance carrier.

Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

Time Based Modalities (Constant Attendance):

- 97032 – Electrical Stimulation (Manual), to one or more areas, (15 minute intervals)
- 97033 – Iontophoresis, (15 minute intervals)
- 97034 - Contrast bath, (15 minute intervals)
- 97035 - Ultrasound, (15 minute intervals)
- 97036 - Hubbard tank, (15 minute intervals)
- 97039 – Unlisted Modality (specify type and time if constant attendance/laser, fluidotherapy, anodyne therapy, VAX-D)

Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

Time-based Therapeutic Procedure Codes:

- 97110 – Therapeutic exercise: to develop strength, endurance, range of motion, and flexibility to one or more areas
- 97112 – Neuromuscular Reeducation: restoring movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (i.e. Baps Board, Trampoline, Swiss Ball, Body Blade, PNF, NDT, etc.)
- 97113 - Aquatic therapy: includes therapeutic exercise
- 97116 - Gait training: includes stair climbing and all phases of gait

Revenue Cycle Management- Delivery of Services/Products (Timed vs Untimed Codes)

Time-based Therapeutic Procedure Codes:

- 97124 – Massage: for muscle relaxation, increased circulation, soft and scar tissue, or mobilize mucus secretions in the lung
- 97140 - Manual therapy techniques: Use of hands to administer joint mobilization, manipulation, range of motion, soft tissue mobilization, and therapeutic massage
- 97530 – Therapeutic Activities: Use of dynamic therapeutic activities designed to achieve improved functional performance (i.e. lifting, pulling, pushing, carrying, etc)

Revenue Cycle Management- Delivery of Services/Products (FLR)

Functional Limitation Reporting:

- The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA), Section 3005(g) requires CMS to implement a claims-based data collection strategy for outpatient therapy services which went into effect on July 1, 2013.
- CMS will use the data collected to reform the Medicare payment system for outpatient therapy.
- The reporting system is designed to gather changes in patient function and condition, therapy services furnished, and outcomes achieved throughout an episode of care.

Revenue Cycle Management- Delivery of Services/Products (FLR)

- FLR codes are used to identify what type of functional limitation is being reported and whether the report is on the current status, projected goal status, or discharge status of the patient
- Severity modifiers indicate the severity/complexity of the functional limitation being tracked
- Applies to therapy services provided to Medicare patient including when Medicare is Secondary
- Does not apply to Medicare Advantage plans unless the plan specifically requires them.

Revenue Cycle Management- Delivery of Services/Products (FLR)

What to Report:

- Report the beneficiary's primary functional limitation defined as the most clinically relevant functional limitation at the time of the initial therapy evaluation.
- When the patient has more than one functional limitation, the therapist will need to determine which one is primary, based on:
  - Most clinically relevant to a successful outcome for the patient
  - The one that will yield the quickest and/or greatest functional progress
  - The one that is the greatest priority for the patient

Revenue Cycle Management- Delivery of Services/Products (FLR)

When to Report:

- Initial Evaluation - Applies to 97161, 97162, 97163, 97165, 97166, & 97167
- Re-evaluations and Progress Reports (minimum every 10th visit)- applies to 97164 & 97168
- At discharge from therapy
- To end reporting of one functional limitation
- To begin reporting of a different functional limitation

Revenue Cycle Management- Delivery of Services/Products (FLR)

Mobility: Walking & moving Around

- G8978 - Mobility: walking and moving around functional limitation, current status, at therapy, episode outset and at reporting intervals
- G8979 - Mobility: walking and moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or end reporting
- G8980 - Mobility: walking and moving around functional limitation, discharge status, at discharge from therapy or to end reporting

Changing & Maintaining Body Position

- G8981 - Changing and maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals
- G8982 - Changing and maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- G8983 - Changing and maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting

Revenue Cycle Management- Delivery of Services/Products (FLR)

Carrying, Moving & Handling Objects

- G8984 - Carrying, moving, and handling objects functional limitation, current status, at therapy episode outset, and at reporting intervals
- G8985 - Carrying, moving and handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- G8986 - Carrying, moving, and handling objects functional limitation, discharge status, at discharge from therapy, or to end reporting

Self Care

- G8987 - Self care functional limitation, current status, at therapy episode outset, and at reporting intervals
- G8988 - Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- G8989 - Self care functional limitation, discharge status, at discharge from therapy or to end reporting

Revenue Cycle Management- Delivery of Services/Products (FLR)

Other PT/OT Primary Functional Limitation:

- G8990 - Other physical or occupational primary functional limitation, current status, at therapy episode outset, and at reporting intervals
- G8991 - Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- G8992 - Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting

Other PT/OT Subsequent Functional Limitation:

- G8993 - Other physical or occupational subsequent functional limitation, current status, at therapy episode outset, and at reporting intervals
- G8994 - Other physical or occupational primary subsequent limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- G8995 - Other physical or occupational primary subsequent limitation, discharge status, at discharge from therapy or to end reporting

Revenue Cycle Management- Delivery of Services/Products (FLR)

Impairment Limitation Restriction	Modifier
0 percent impaired, limited or restricted	CH
At least 1 percent but less than 20 percent impaired, limited or restricted	CI
At least 20 percent but less than 40 percent impaired, limited or restricted	CJ
At least 40 percent but less than 60 percent impaired, limited or restricted	CK
At least 60 percent but less than 80 percent impaired, limited or restricted	CL
At least 80 percent but less than 100 percent impaired, limited or restricted	CM
100 percent impaired, limited or restricted	CN

Revenue Cycle Management- Back End Processes (Common Modifiers)

Coding- Modifiers common in PT/OT practice:

- **GP**- modifier that indicates that a patient is receiving outpatient physical therapy.
- **GO**- modifier that indicates that a patient is receiving occupational therapy.
- **KX**- modifier that signifies that we acknowledge that the patient is nearing or exceeding the cap, but therapy is still medically necessary ($1980 for PT and ST combined, separate $1980 for OT).
- **59**- used to identify procedures (and/or) services that are not normally reported together, but are appropriate under the circumstances
- **25**- Physician and PT visit same day (on physician claim)
- **CH, CI, CJ, CK, CL, CM, CN-** severity modifiers appended to the FLR codes signifying the amount of severity of functional impairment.

Revenue Cycle Management- Back End Processes

Monitoring payments:

- Denials- National average: 5 – 25%
- Days in A/R- National average:
  - 32 – 35 day average
  - 55% <30 days
  - 23% > 90 days
- Net Collections
- Payer Mix- payments, adjustments, denials