A Physical Therapist's Toolbox to Billing, Coding and Coverage for Integumentary Care and Wound Management

January 2018

Academy of Clinical Electrophysiology & Wound Management

A Wound Management Special Interest Group White Paper

A Physical Therapist's Toolbox to Billing, Coding and Coverage for Integumentary Care and Wound Management

Purpose:

The purpose of this report is to educate physical therapy professionals involved in integumentary care and wound management on the reimbursement system that provides payment for therapy services and related ancillary supplies and equipment. This paper provides the necessary tools for a physical therapist to obtain reimbursement for their services.

The Academy of Clinical Electrophysiology & Wound Management's (ACEWM) Wound Management Special Interest Group (WMSIG) is proud to produce this white paper in support of physical therapists across the nation practicing in wound management.

Co-Chairs:
Shari Orphey, PT, DPT, CWS, FACCWS,
CLT Tim Paine, PT

Co-Authors:
Shari Orphey PT, DPT, CWS, CLT,
FACCWS Tim Paine, PT
Lisa Cabral, PT, DPT, CWS, CLT
Sonya Dick, PT, DPT, CWS,
FACCWS
Melissa Johnson, PT, DPT, CWS

Task Force Members:
Frank Aviles Jr., PT, CWS, WCC, CLT,
FACCWS
Amy Bala, PT, MPT, CWS, WCC, FACCWS
Lisa Cabral, PT, DPT, CWS,
CLT
Rene Canas, PT, DPT, CWS
Michelle Deppisch, PT, CWS, FACCWS
Sonya Dick, PT, DPT, CWS,
FACCWS
Anne Gallentine, PT, CWS

Betty Holder, PT, MS, CWS
Melissa Johnson, PT, DPT,
CWS
Holly Korzendorfer, PT, PhD, CWS,
FACCWS
Michael Reed, PT, CWS
Mark Richards, PT
Calandra Shannon, PT, DPT, CWS
Holly Smith-Mangrum, PT, DPT, CWS
Karen Wilcox, PT, CWS, CLT

A Physical Therapist's Toolbox to Billing, Coding, and Coverage for Integumentary Care and Wound Management

January 2018

Physical therapists (PTs) encounter patients with loss of skin integrity and wound impairments in all clinical settings. Per the *Guide to Physical Therapist Practice* and a review of all state physical therapy practice acts, it is within a physical therapist's scope of practice to provide integumentary care/wound management services[25]. Wound management is needed for uncomplicated, non-refractory wounds as well as wounds that are refractory or have complicated healing cycles due to the nature of the wound itself or hindering metabolic and /or physiological factors. Wound management includes therapeutic techniques that enhance the healing of open or closed tissue injuries.

PTs recognize that contributing to the financial success of our organization creates opportunities for clinical success and grows our ability to provide service in niche markets, such as integumentary and wound management. The physical therapist's education and training in comprehensive patient care is ideal for participating in interdisciplinary teams.

Every PT, regardless of experience, needs to understand the reimbursement system that provides payment for therapy services and related ancillary supplies and equipment. To understand this system, it is important to focus on a few specific questions, such as:

1. What are the patient's physical and functional deficits?
2. What are the appropriate interventions PTs can provide to the patient?
3. What is the patient's insurance coverage? Why is this important for a PT to know?
4. How can PTs locate information regarding which procedure codes are covered by their patient's insurance?

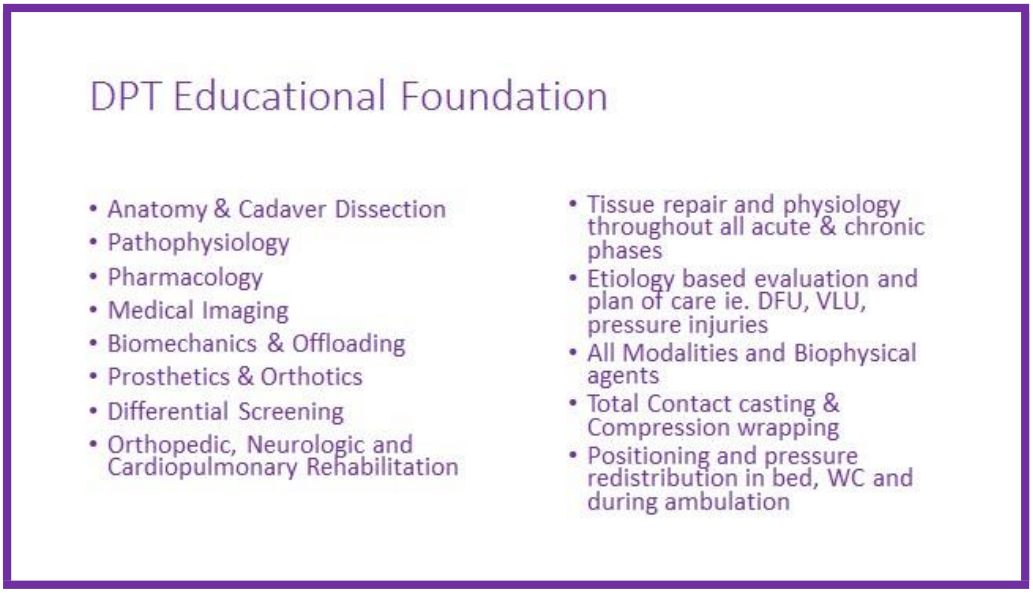
What are the patient's physical and functional deficits?

Patients with integumentary disruption exist in all age categories. They may have loss of function from a variety of medical diagnoses including, but not limited to, organ dysfunction such

as kidney failure or cardiac insufficiency; diabetes; cancer; trauma; surgery; excessive skin pressure; thermal burn, or dermatologic conditions such as scleroderma or bullous pemphigoid. These patients can benefit from treatments to promote integumentary repair, improve safe and functional mobility, increase strength /or range of motion (ROM), and education regarding their wound and health promotion. PTs perform comprehensive evaluations and develop plans of care to address patient-specific needs inclusive of wound management and any associated functional limitations that can be a cause or sequelae of integumentary disruption. When identifying a patient's specific physical and functional deficits, the PT begins the process of effective billing and coding.

What are the appropriate interventions which may be provided by PTs for the benefit of the patient?

PTs have the foundational academic and clinical skills to offer unique wound management services to patients affected by wounds or integumentary issues. PTs receive foundational training in anatomy, physiology, pathology, kinesiology, medical and surgical conditions, as well as the clinical sciences pertaining to the integumentary, lymphatic, cardiovascular, respiratory, musculoskeletal, nervous, endocrine, metabolic, immune, gastrointestinal, urologic, reproductive, hematologic, hepatic and renal systems. [1-3] This expertise is applicable across the life span.



PTs who choose to specialize in wound management have additional training to further advance their knowledge and skill. Although PTs have the ability to perform sharp debridement with their entry level degrees, there are post-graduate continuing education and certification courses to assist PTs in honing these skills.[4] To promote higher standards in the field of wound management, the American Board of Wound Management offers the Certified Wound Specialist® (CWS®) credential[5] and the Wound Care Education Institute offers Wound Care Certified (WCC) credentialing.[6] Certified wound care professionals with an interest in evidence-based wound management can obtain Fellow status credentialing (FACCWS)[7] from The American College of Clinical Wound Specialists™. To further develop the PTs expertise in the

field of wound management, Louisiana State University Health Sciences Center - Shreveport offers a wound care residency. [8] As of the writing of this paper, a second residency program in wound management is being developed in California and the ACEWM is in the process of seeking wound management clinical specialization from the American Board of Physical Therapy Specialties. PTs also may specialize in lymphedema management and wounds associated with
impaired lymphatic systems and acquire the Certified Lymphatic Therapist (CLT) certification.[9-11] Additionally, PTs must comply with annual or biennial continuing education requirements to maintain their state license.

PTs provide comprehensive evaluations and assessments of patients with integumentary and/or wound issues and identify all impairments that may benefit from physical therapy intervention.

A comprehensive plan of care incorporating the individual needs of the patient ensures the most optimal outcome. Areas of focus may include functional activity training, exercise prescription, fall prevention, orthotic and prosthetic training, positioning education, assistive device training, seating and offloading recommendations and training, and education. Through this comprehensive management model the PT can provide unique value as a member of the interdisciplinary team.

State licensure and unique training during entry-level education allow the PT to perform sharp selective debridement, which can significantly augment wound healing, often coupled with adjunctive wound modalities, in any patient care setting. Specific interventions that are part of physical therapist practice include electrical stimulation, diathermy, compression wrapping, low-frequency contact and non-contact ultrasound, ultraviolet light, monochromatic infrared energy, lasers, pulsatile lavage, negative pressure wound therapy, and total contact casting.[12] These modalities are proven to increase cell activity, reduce pain and inflammation, reduce bacterial activity and viability, remove non-viable tissue and decrease tissue loading pressures. [13-24] All have the potential to bring value to the patient and the inter-professional team.

Additionally, PT services can address co-morbidities and impairments that occur in patients with wounds, including deficits in strength, mobility, ROM, comfort and especially functional abilities. Physical therapist services are the primary intervention for persons with these deficits and can augment wound healing as well as decrease the risk of wound progression and/or recurrence.

For the PT who works in a niche practice area such as wound management it is helpful to remember that PTs assess the whole person, not just the “problem area”, and identify physical impairments and functional deficits. This broad assessment leads to the development of a clinical plan that is individualized and appropriate to the patient’s specific needs and situation, avoiding the pitfall of recipe-based thinking: *problem A is addressed only with treatment 1*.

What is the patient’s insurance coverage and why is this important to PTs?

It is critical that PTs understand their role within the process that connects the clinical intervention to reimbursement. This process is a complex system involving correct coding of diagnoses, services or procedures provided, site of service and G-codes. The provider

generates a bill using these codes to present to the payment entity, such as Medicare or private insurance. Each step of this process is affected by local, state and federal regulations; professional and facility licenses; and payer policy. Since the reimbursement process and sets of regulations can be confusing and include the use of numerous abbreviations, having a list of common acronyms can be helpful. **See Attachment A: Common Acronyms in Wound Care Reimbursement.**

Most insurance payers fall into one of four categories:

a. Government insurance (e.g. Medicare, Medicaid, Tricare, Veterans Affairs)
b. Commercial insurance (purchased individually or through the employer; examples include CIGNA, Blue Cross and Blue Shield, and United Healthcare)
c. Worker's Compensation insurance (medical coverage to treat a problem that occurred as part of a person's employment duties)
d. Marketplace or Affordable Care Act payers

Some third-party payers require pre-authorization before treatment may begin. The payer will review the physical therapy evaluation documentation and approve a specific number of visits over a specific time period for specific treatment. Any services provided outside this approval will not be paid. If services are desired outside the pre-authorization (e.g. more visits, more modalities/other interventions, more treatment sessions), the payer must be contacted with a request for additional services. Some payers will allow for retro-authorization if prior authorization was not completed. Others will not allow this and payment may be denied.

Other payers review documents after services are provided and payment has been received (post-payment reviews). If physical therapist services were found not to be *medically necessary* (therapy documentation does not meet the insurer's criteria for justifying the treatment) the provider may need to pay the third-party payer back. Each insurer has coverage determinations that include descriptions of medical necessity information regarding coverage and non-coverage.

Medicare recipients:

Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. This determination by the Centers for Medicare and Medicaid Services is called a National Coverage Determination (NCD). NCDs are made through an evidence-based process with opportunities for public participation. In the absence of a NCD, an item or service is covered at the discretion of the Medicare contractor. A Medicare contractor is a private insurer that has been awarded a geographic jurisdiction to process Medicare Part A and B claims, or durable medical equipment claims. When there is no NCD or when there is a need to further define a NCD, Medicare contractors develop a Local Coverage Determination (LCD). The LCD is a decision by a Medicare contractor as to what the coverage rules are for a particular service or item within that contractor's geographical jurisdiction. The guidelines for LCD development are provided in Chapter 13 of the Medicare Program Integrity Manual. The LCDs discuss under what circumstances an item or service is considered reasonable and necessary. NCDs and LCDs can be located on the Medicare Coverage Database.

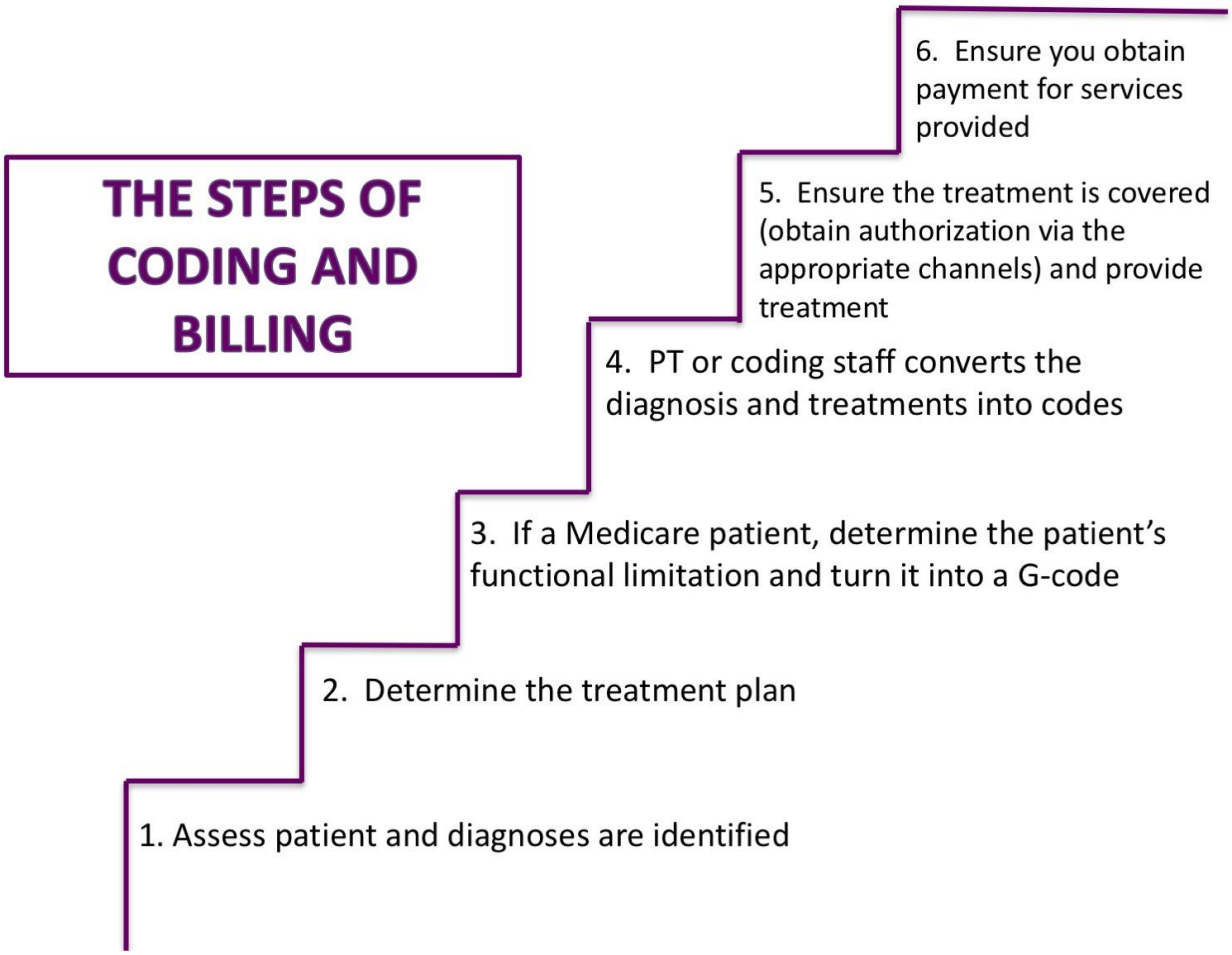
CMS provides access to local and national coverage determinations. The CMS website, *https://www.cms.gov/medicare-coverage-database/* should be utilized to determine the coverage policy and local or national determinations for Medicare patients in your area.

How can PTs find information regarding which procedure codes are covered?

Treatment interventions are translated into Current Procedural Terminology (CPT) codes, which are the standard codes set for how medical professionals document and report medical services. All health care providers, payers, and facilities use CPT codes. CPT codes are developed, maintained, and copyrighted by the American Medical Association. CPT codes are included on Medicare claims. Proper coding is necessary on Medicare claims because codes generally are used in determining coverage and payment amounts.

NCDs and LCDs must be reviewed to assure these CPT codes are covered in your region prior to being added to the charge master or super bill and used in your setting. CPT codes are always subject to revision; PTs must be aware of any changes so they know which CPT code(s) to include on the claim as well as in what instances your Medicare Administrative Contractor covers that service. For example, new CPT codes were implemented in 2017 for Physical Therapy Evaluations and the Re-evaluation. Another example: at the time of this writing, Cahaba MAC does not cover Unna boot billing procedure 29580 for wound management. It is covered only for dislocation and fractures. So, for the Cahaba MAC you would not utilize this code for wound management, but rather use the multilayer compression code 29581. **See Attachment B: CPT Codes for PTs** (includes a copy of the APTA's 2016 *Quick Guide to the 3 Levels of Physical Therapy Evaluation*)

The agreement between providers and payers (e.g. Medicare, Medicaid, commercial insurers) stipulates the rules to follow when submitting a bill for services. Not only is it a breach of contract if the rules are not followed, but also it is fiscally irresponsible to provide therapist services without understanding and meeting the requirements for payment. For these reasons it is important that the therapy provider verifies insurance coverage for services to be provided. The steps for insurance verification are outlined in the table below. The provider will contact the payer by phone, email or on their website. Contact information typically is listed on the patient's insurance card. Communication will confirm the patient has coverage for physical therapy, any coverage limitations, how to submit claims correctly, and what documentation is required for a claim to be paid.



Here is one example of the coding and billing process. *Note that each facility will have variations of this example.*

1. A new patient is examined and appropriate diagnoses are identified
   a. Diagnoses are identified by assessment findings.
   b. Diagnoses are prioritized- with the primary diagnosis first. This diagnosis is what the PT interventions will be addressing. There may be additional diagnoses that support the primary diagnosis, e.g. primary diagnosis is a code that identifies the wound, and the secondary code identifies the underlying contributing factor(s)

   NOTE: look at the APTA website for more in-depth information on how to choose a diagnosis
2. The PT will identify treatment interventions that are appropriate to address the primary diagnosis - AND are within the scope of practice in his/her state - AND are allowed within the site of service (e.g. outpatient clinic, hospital or other site of service) - AND are allowed by the facility
3. The PT will identify the patient's impairments, activity limitations, and participation restrictions during the evaluative process. Currently, Medicare requires these findings be converted to codes. These codes are called "G-codes". Currently, the areas of activity limitations are:
   a. Self-care
   b. Walking and moving around

c. Changing and maintaining body position
d. Carrying, moving and handling objects

Once identifying the area of limitation, the PT uses testing to identify the severity modifier that reflects the patient's percentage of functional impairment as determined by the therapist, e.g. 0-20%, 21-40%, 41-60%, 61-80% and 81-100% impairment. The combination of impairment code and % of impairment is entered into the claim form. An example is the code and modifier "G8978 CI"- indicates a walking and moving around impairment of at least 1% but less than 20%. If the patient has a T10 complete spinal cord transection with resultant paraplegia, and has a subsequent pressure ulcer, the G-code utilized may be "Changing and Maintaining Position" and part of the wound care services will include transfer training and education regarding offloading and appropriate pressure re- distribution equipment. In the event there are not functional objectives of treatment and the therapist will exclusively be addressing the integumentary and/or wound, issue the therapist would use the other OT/PT Category and the CH modifier.

Learn more about G-codes here:
www.apta.org/Payment/Medicare/CodingBilling/FunctionalLimitation/

4. The PT will determine the most appropriate diagnoses and procedure codes to describe the patient's presentation and the interventions that will be provided. The supportive documentation must "tell a story" about the patient and his/her needs, identify the medical necessity for the services, and give a clear rationale for their provision. Additionally, the treatment codes will follow the payer policy established by the payer. Some interventions are timed (paid based on the amount of time spent providing the service), some are untimed (a flat rate paid regardless of the time spent). Some codes may be billed on the same day, and some may not.
5. If multiple procedures are performed, it is the National Correct Coding Initiative (NCCI) edits for coverage of multiple procedures in one treatment session/visit that will need to be understood and followed. There are software programs available that can assist the therapist when checking on coverage of specific procedures. The link to the CMS procedure manual is:
   cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
6. The PT will provide treatment according to the plan of care. Eligibility for payment for this treatment is determined by answering the following four questions:
   a. Does it follow the plan of care identified by the evaluation?
   b. Does it meet the payer's definition of medical necessity?
   c. Does it meet all approval/authorization/limitations in the patient's insurance plan?
   d. Is it within the therapist's scope of practice?

   If the therapist answers "no" to any of the questions, payment likely will be denied, withheld, or recouped.
7. Once the service has been provided and the correct codes applied, a bill (or claim) is generated and sent to the insurer. The payer will process the claim and pay what they identify as the correct amount, based on the patient's evidence of coverage (EOC). The payer will send the patient and provider an Explanation of

Benefit (EOB), along with the payment they have identified as appropriate. This EOB will identify the date of service, service provider (Joe Jones, PT, DPT), services provided (97001, 97035), what amount was billed on the claim, what amount was paid, and how that amount was determined. For example, of the billed amount of $245.89, the insurance plan allows $175.45, and covers 70% after a $35.00 co-pay. This means of the $245.89 billed, the provider is paid $87.81 by the insurer, and must collect $35.00 from the patient for his/her co-pay.

8. The provider (and/or the accounts receivable staff) reviews the EOB, assesses if the correct amount was paid, and if not, contacts the insurance company.

It is critical that all providers understand this basic process. Each time a provider submits a claim, it is a legal document stating services rendered, need for service, and the request for payment. If the treatment codes are not supported by the diagnostic codes, (e.g. the diagnosis is an ulceration code and the PT provided therapeutic exercises – *and has not identified a strength or ROM deficit)* the claim will be rejected. If this is a pattern it may result in adverse actions. These include "red flagging" of this provider's claims which may result in closer scrutiny and more rejections, an audit of clinical and billing records, a request for payback of previously paid claims, or if considered egregious, legal action for fraudulent billing practices.

Helpful Reminders

MAC = Medicare Administrative Contractors
NCD = National Coverage Determination
(created by Medicare and Medicaid) LCD = Local Coverage Determination

A MAC develops an LCD if there is no NCD or, when clarification is needed about an NCD. An NCD always trumps an LCD.

In addition to this paper, there are resources that will assist the PT in learning more about correct coding and billing, as well as how to review billing processes on a regular basis to keep current with changes in regulations, insurer rule changes and coding updates. These include the payer's website, the APTA website, your facility billing team and, if you use a billing service, their billing team. **See Attachment C: Frequently Asked Questions and Attachment D: Billing Tool**

One question often asked is "How can physical therapy help my patients with wounds and be cost effective?" PTs need to identify where they can help, what they can offer, and if they can provide the service in a fiscally responsible manner. PTs must utilize clinical reasoning,

overlay their awareness of the coding and billing process for the organization, and then determine if they can provide a service that will:

a. Help the patient progress toward an identified goal (e.g. improved wound healing, improved function, decreased pain, decreased edema)
b. Be an appropriately billable service (are the procedural codes approved by the payer for the diagnoses identified?)
c. Contribute in a meaningful way to the overall treatment plan (Can PT provide services at the correct time, in the correct way, and without interfering with other portions of the overall treatment plan, and do those services require the skills of a physical therapist for this patient?)
d. Be provided in the most cost-effective manner

In summary, it is the responsibility of the provider not only to provide appropriate services, but also to work within the complex system of coding and billing. In doing so, PTs act as responsible stewards of resources while maximizing their clinical value to the patient and the organization.

References

1. Commission of Accreditations in Physical Therapy Education. Standards and Required Elements for Accreditation of Physical Therapist Education Programs. *CAPTE*. http://www.capteonline.org/uploadedFiles/CAPTEorg/About_CAPTE/Resources/Accreditation_Handbook/CAPTE_PTStandardsEvidence.pdf. Published November 11, 2011. Accessed May 26, 2017.
2. Commission of Accreditations in Physical Therapy Education. Evaluative Criteria in PT Programs. *CAPTE*. http://www.capteonline.org/uploadedFiles/CAPTEorg/About_CAPTE/Resources/AccreditationHandbook/EvaluativeCriteria_PT.pdf. Published August 2014. Accessed January 4, 2018.
3. Federation of State Boards of Physical Therapy. Results of PT and PTA Program Textbook Survey. *FSBPT*. http://www.fsbpt.org/Portals/0/documents/free-resources/TextbookSurveyResults201103.pdf. Accessed January 4, 2018.
4. Advanced wound debridement: a cut above the rest http://www.sharpdebridement.com . Accessed January 4, 2018.
5. American Board of Wound Management. [Wound Certification] *ABWM.* http://www.abwmfoundation.org. Accessed January 4, 2018.
6. Wound Care Education Institute. [Skin, Wound, Diabetic and Ostomy Management Certification] *WCEI.* https://www.wcei.net/. Accessed January 4, 2018.
7. The American College of Clinical Wound Specialists. [Wound care education and credentialing] *ACCWS.* http://www.accws.org/. Accessed January 4, 2018.
8. LSU Health Shreveport. Post professional Residencies. *LSUshreveport.* http://www.lsuhscshreveport.edu/departments/AlliedHealth/AHDepartments/PhysicalTherapy/ptpostpro/index. Accessed January 4, 2018.
9. Norton School of Lymphatic Therapy. Why become a certified lymphatic therapist? *NSOLT*. http://www.nortonschool.com. Accessed January 4, 2018.
10. Lymphology Association of North America. Find a LANA certified therapist. *LANA.* http://www.clt-lana.org/search/therapists/. Accessed January 4, 2018.
11. National Lymphedema Network NLN. http://lymphnet.org/. Accessed January 4, 2018.
12. Myers B. *Wound Management, Principles & Practice*. 3rd ed. Pearson Prentice Hall: New Jersey; 2012.
13. Ennis WJ, Lee C, Meneses P. A biochemical approach to wound healing through the use of modalities. *Clin Dermatol*. 2007; *25*(1), 63-72.
14. Peplow PV, Chung TY, Baxter GD. Application of low level laser technologies for pain relief and wound healing: overview of scientific bases. *Phys Ther Rev*. 2010; *15*(4), 253-285.
15. Kloth LC. Electrical stimulation for wound healing: a review of evidence from in vitro studies, animal experiments, and clinical trials. *Int J Low Extrem Wounds*. 2005; *4*(1), 23-44.

16. Falagas ME, Tansarli GS, Kapaskelis A, Vardakas KZ. Impact of vacuum-assisted closure (VAC) therapy on clinical outcomes of patients with sternal wound infections: a meta- analysis of non-randomized studies. *PLoS ONE*. 2009; 8(5): e64741. doi:10.1371/journal.pone.0064741.
17. Beckmann KH, Meyer-Hamme G, Schröder S. Low level laser therapy for the treatment of diabetic foot ulcers: a critical survey. *Evidence-Based Complementary and Alternative Medicine*, vol. 2014, Article ID 626127, 9 pages, 2014. Doi:10.1155/2014/626127.
18. Driver VR, Yao M, Miller CJ. Noncontact low-frequency ultrasound therapy in the treatment of chronic wounds: A meta-analysis. *Wound Repair Regen*. 2011; *19*(4), 475-480.
19. Hess CL, Howard MA, Attinger CE. A review of mechanical adjuncts in wound healing: hydrotherapy, ultrasound, negative pressure therapy, hyperbaric oxygen, and electrostimulation. *Ann Plast Surg*. 2013; 51(2), 210-218.
20. Tavusbay C, Kar H, Cin N, Kamer E, Aksut H, et al. The use of vacuum-assisted wound closure system for management of difficult wounds. *Biomed Res*. 2013; *24*(3), 329-336.
21. Baker KG, Robertson VJ, Duck FA. A review of therapeutic ultrasound: biophysical effects. *Phys Ther*. 2001; 81(7), 1351-1358.
22. Dai T, Vrahas MS, Murray CK, Hamblin MR. Ultraviolet C irradiation: an alternative antimicrobial approach to localized infections? *Expert Rev Anti Infect Ther*. 2012; 10(2):185-195. doi:10.1586/eri.11.166.
23. Kushagra S, Chauhan VD, Maheshwari R, Chauhan N, Rajan M, Agrawal A. "Vacuum assisted closure therapy versus standard wound therapy for open musculoskeletal injuries." *Adv Orthop*. 2013; 2013:245940. Doi:10.1155/2013/245940.
24. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.
25. Guide to Physical Therapy Practice 3.0, American Physical Therapy Association, http://guidetoptpractice.apta.org/content/current, Accessed 11/8/2017

Attachment A: Common Acronyms in Wound Care Reimbursement

APC	Ambulatory Payment Classification
ASP	Average Sales Price
CERT	Comprehensive Error Rate Testing
CMS	Center for Medicare & Medicaid Services
CPT Code	Common Procedural Terminology Code
CTP	Cellular and/or Tissue-based Product for wounds
DME	Durable Medical Equipment
DMERC	Durable medical equipment regional carrier
G-Codes	Functional Codes used as modifiers on therapy services
HCPCS	Healthcare Common Procedure Coding Services
HOPD	Hospital-based Outpatient Department
ICD- 10 CM	International Classification of Diseases, 10th revision clinical modification
LCD	Local Coverage Decision
MAC	Medicare Administrative Contractor
MCD	Medicare Coverage Database
NCCI edits	National Correct Coding Initiative
NCD	National Coverage Determination
PQRS	Physician Quality Reporting System
PTP NCCI	Procedure-To-Procedure NCCI edits
QHP	Qualified Healthcare Professional
RAC	Recovery Auditing Contractor
SMRC	Supplemental Medical Review Contractor
ZPIC	Zone Program Integrity Contractor

Attachment B: Physical Therapy CPT Codes

97001	PT Evaluation (deleted 1/2017)
97161	PT Evaluation: Low Complexity (new 1/2017)
97162	PT Evaluation: Moderate Complexity (new 1/2017)
97163	PT Evaluation: High Complexity (new 1/2017)
97002	PT Re-evaluation (deleted 1//2017)
97164	PT Re-evaluation (new 1/2017)
97010	Hot or Cold Pack Therapy
97012	Mechanical Traction
97016	Vasopneumatic Device Therapy
97018	Paraffin Bath Therapy
97022	Whirlpool Therapy
97024	Diathermy E.g. Microwave
97026	Infrared Therapy
97028	Ultraviolet Therapy
97032	Electrical Stimulation
97033	Electric Current Therapy
97034	Contrast Bath Therapy
97035	Ultrasound Therapy
97036	Hydrotherapy
97039	Physical Therapy Treatment
97110	Therapeutic Exercise
97112	Neuromuscular Reeducation
97113	Aquatic Therapy/exercise
97116	Gait Training Therapy
97124	Massage Therapy
97139	Physical Medicine Procedure
97140	Manual Therapy 1/> Regions
97150	Group Therapeutic Procedures
97530	Therapeutic Activities
97535	Self Care Management Training
97537	Community/Work Reintegration
97542	Wheelchair Management Training
97597	Wound Care Selective First 20 sq cm
97598	Wound Care Selective Additional 20 sq cm
97602	Wound Care Non-Selective
97605	Negative Pressure Wound Therapy < or = to 50 sq cm
97606	Negative Pressure Wound Therapy > 50 sq cm
97607	Negative Pressure Wound Therapy <50 sq cm w/ disposables non DME
97608	Negative Pressure Wound Therapy > 50 sq cm w/ disposables non DME

97610	Low Frequency, Non-Contact, Non-Thermal Ultrasound
97750	Physical Performance Test
97755	Assistive Technology Assess
97760	Orthotic Management and Training
97761	Prosthetic Training
97762	C/O for Orthotic/Prosthetic Use
G0281	Electrical Stimulation Unattended for Press
G0283	Electrical Stimulation Other than Wound
G0329	Electromagnetic therapy for wounds; pressure, arterial, venous and diabetic ulcers
29581	Multilayer compression wraps, ankle and foot
29582	Multilayer compression wraps, thigh and leg including ankle and foot
29583	Multilayer compression wraps, upper arm and forearm
29584	Multilayer compression wraps, upper arm and forearm including hand and fingers

PHYSICAL THERAPY EVALUATION REFERENCE TABLE

~~97001~~

97161
97162
97163

Three new codes—97161, 97162, and 97163—replace the single 97001 CPT code for physical therapy evaluation beginning January 1, 2017.

How to use this guide:

Physical therapy evaluations require the following components in selecting the correct evaluation level—History, Examination, Clinical Presentation, and Clinical Decision Making. Additional guiding factors include coordination, consultation, and collaboration of care consistent with the nature of the problem and the needs of the patient. The table on page 2 summarizes the requirements for reporting physical therapy evaluation services.

DEFINITIONS FOR TERMS IN THE TABLE (page 2)

Activity limitations: Di culties an individual may have in executing a task, action, or activities (eg, inability to perform tasks due to abnormal vital sign response to increased movement or activity).

Body functions: The physiological functions of body systems, including psychological functions

Body regions: In reporting physical therapy evaluations, body regions are defined as head, neck, back, lower extremities, upper extremities, and trunk.

Body structures: The structural or anatomical parts of the body, such as organs, limbs, and their components, classified according to body systems

Body systems: In reporting physical therapy evaluations, the systems review includes the following:

- For the cardiovascular/pulmonary system: the assessment of heart rate, respiratory rate, blood pressure, and edema
- For the integumentary system: the assessment of pliability (texture), presence of scar formation, skin color, and skin integrity
- For the musculoskeletal system: the assessment of gross symmetry, gross range of motion, gross strength, height, and weight
- For the neuromuscular system: a general assessment of gross coordinated movement (eg, balance, gait, locomotion, transfers, and transitions) and motor function (motor control and motor learning)
- For communication ability, a ect, cognition, language, and learning style: the assessment of the ability to make needs known, consciousness, orientation (person, place, and time), expected emotional/behavioral responses, and learning preferences (eg, learning barriers, education needs)

Participation restrictions: Problems an individual may experience in involvement in life situations (eg, inability to engage in community social events due to exhaustion).

Personal factors: Factors include sex, age, coping styles, social background, education, profession, past and current experience, overall behavior pattern, character, and other factors that influence how disability is experienced by the individual. Personal factors could exist but may or may not negatively impact the physical therapy plan of care.

PHYSICAL THERAPY EVALUATION REFERENCE TABLE

CPT© Code	97161	97162	97163
Required Components (all are required in selecting evaluation level)			
History			
no **personal factors** and/or comorbidities	X		
1-2 **personal factors** and/or comorbidities		X	
3 or more **personal factors** and/or comorbidities			X
Examination of body system(s) (elements include body structures and functions, activity limitations, and/or participation restrictions)			
addressing 1-2 elements	X		
addressing a total of 3 or more elements		X	
addressing a total of 4 or more elements			X
Clinical Presentation			
Stable	X		
Evolving		X	
Unstable			X
Clinical Decision Making (complexity)			
	low	moderate	high
Development of Plan of Care			
Additional Guiding Factors			
Coordination, consultation, and collaboration of care with physicians, other qualified health care professionals, or agencies is provided consistent with the nature of the problem(s) and the needs of the patient, family, and/or other caregivers.			
Typical Face-to-Face Time (minutes)	20	30	45

An additional new code, 97164, replaces 97002 for physical therapy reevaluation.

NOTE: These codes replace 97001 for Medicare and commercial payers; claims for worker's comp and auto liability may continue to use 97001.

(See page 1 for definitions of terms highlighted in blue.)

APTA
American Physical Therapy Association

Attachment C: Frequently Asked Questions

1. Why is billing important?
    a. When we bill for services, we are stating we have provided certain services, that the services were medically necessary, that the services are designed to address problems as identified in the plan of care. Most importantly, we are stating the bill is accurate and follows the rules as stated in the contract signed by the provider. If we bill incorrectly, we not only delay being paid for appropriate services, but also we are not fulfilling our duty to follow the contract with the insurance company and may be penalized. Penalties may include increased scrutiny/audits of our billing practices, financial penalties and even legal proceedings for fraudulent billing.
2. How do I know what diagnosis to use?
    a. The diagnosis is chosen based upon the evaluation, and should be consistent with the diagnosis from the referring physician.
3. Are there procedures for which I cannot bill?
    a. These are determined by the contract with the insurance company, the state practice act for your s tate and the policies of your facility.
4. What is Medical Necessity?
    a. Medical Necessity means the treatment procedure is appropriate to address the diagnosis. Most insurance companies have a matrix matching what diagnoses are appropriate for each procedure code, and some of these matrices are available to the provider.
5. Whom do I call with my billing questions?
    a. Speak to your facility billing expert or insurance provider liaison to get answers to billing questions.
6. How do I know if I get paid for a certain modality?
    a. Speak to your facility billing expert or insurance provider liaison to get answers to billing questions.
7. How do I find the rules for billing?
    a. Payer policy is one source for information related to a specific payer or plan. Another source is the provider contract with the payer. Additionally, a practice setting may have someone designated as the billing expert. This person may be contacted to answer specific billing questions for your setting. Another source of information is the insurance company. Most insurance companies have staff to answer questions from providers. Be sure to ask for written documentation regarding the answer you receive (this may be an online document or a faxed document. Any time a call is made to a provider, it is
    helpful to document to whom you speak and the information they provide.

8. What is a PT allowed to do in my state?
    a. Every state has a PRACTICE ACT. This practice act states what a professional legally can and cannot do in his/her professional duties. The typical practice act also defines what the professional training is, the licensure rules and regulations, the rules regarding supervision of staff, documentation rules, as well as ethics and rules regarding fraud, abuse and censure. The best way to know what a physical therapist can do is to read and understand your state's practice act. APTA provides the following link to each state's practice act.
    http://www.fsbpt.org/FreeResources/LicensingAuthoritiesContactInformation.as px
9. Why does the setting in which I work matter when I bill?
    a. Insurers have different billing rules for different practice settings. A service may be payable in one setting, but not in another; or, the payable amount may be different in different settings. The setting is determined by the contract with the insurer. Some of the practice settings insurers recognize are:
        i. Acute care – a person is admitted to the hospital
        ii. Acute care - emergency room

iii. Acute care – observation - a person is in the hospital but not admitted
iv. Long term care - includes skilled nursing facilities and some subacute care settings
v. Home care - services provided through a home health agency
vi. Outpatient - services may be provided in the physician's office, therapy office in a skilled nursing facility, or even at home under certain situations
vii. Outpatient surgical center

10. Doesn't every insurance company follow Medicare rules?
    a. No, each insurer has its own rules for billing. Some of these rules may be the same as Medicare, but many are not.
11. How often do the rules for billing change?
    a. The billing rules constantly are updated. New research, new practice patterns, and government and regulatory changes require updates. Many insurers have a listserv or e-blasts that provide updates for subscribers; it is helpful to be a subscriber and keep up with the changes.
12. How has ICD-10 changed billing?
    a. The implementation of ICD-10 has required that diagnostic coding be more accurate. It also requires that the Medical Necessity matrix be updated.
13. How do I improve my billing?
    a. It is a multi-step process
        i. Read and understand the rules for billing in your state, in your practice setting, and for your facility.
        ii. Carefully review each claim to ensure it meets the threshold of Medical Necessity as defined by the insurer, AND that the provider's documentation supports the claim being submitted.
        iii. Review each Explanation of Benefit (EOB) after the insurer's review of the claim to determine if payment was as expected
        iv. If payment was not as expected, investigate why the payment was not made and resubmit the claim for reconsideration with the needed corrections. There is a limited amount of time for resubmission.
14. What is a Bundled Code?
    a. There are some billing codes that include more than the procedure listed. Some codes will include additional services that cannot be billed separately. One example is hot/cold therapy. For Medicare and some private payers, these codes cannot be billed separately as they are "bundled" with therapeutic exercises.
15. What are "timed" and "untimed" codes?
    a. Untimed codes, such as the "Physical Therapy Evaluation" code, are paid the same amount regardless of the time it takes to provide that service
    b. Timed codes are paid an amount for a specific amount of time, typically 15 minutes. If a timed service is provided for longer, the service would be billed for more than the one unit of time. IMPORTANT: it is critical the therapist understand the minimum amount of service time needed, to be a billed service. Medicare has the "8-minute rule" which explains about this minimum time rule.
16. What is a fiscal intermediary?
    a. Medicare contracts the administration of its policies to regional intermediaries. Each of these fiscal intermediaries manage the Medicare benefits for Medicare enrollees living in their territory. The fiscal intermediary may cover multiple states. Each fiscal intermediary interprets Medicare rules for itself, resulting in different coverage in different parts of the country. IMPORTANT: it is important to understand the coverage rules that apply to your location.

Attachment D:
Billing Tool

Billing Tool	Description	Location of Tool	Frequency of Tool Update/Review
Local and National Coverage Decisions	Explains Medicare coverage of procedures based on the MAC region	https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx http://www.apta.org/Payment/Medicare/CoverageIssues/ (review all pertinent to practice i.e., physical therapy, debridement, negative pressure)	Updated frequently Review quarterly
State Practice Act And other therapy related transmittals	Identifies scope of practice within the state to allow certain procedures to be performed legally	http://www.apta.org/Licensure/StatePracticeActs/ http://www.cms.gov/TherapyServices/ http://www.cms.gov/Transmittals (Transmittals are used by cms to communicate policy changes or updates to current procedures or policies)	Yearly (minimally) May have changes throughout year Transmittals may be quarterly
Medicare Physician Fee Schedule	Yearly Medicare Fee reimbursed for each procedure	http://www.cms.gov/Medicare/Neducare-Fee-for-Service-Payment/PhysicianFeeSched/index.html Search tool for CPT code pricing for each code http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx	Annually updated (January)
CPT Procedures	Current Procedural Terminology that identifies current procedures and their definitions	American Medical Association Current Procedural Terminology, CPT BOOK CPT Assistant Publication (www.amacodingonline.com) http://www.apta.org/Payment/Coding/CPTChanges/ https://www.cms.gov/regulations-and-guidance/legislation/clia/downloads/subjecttoclia.pdf	January
ICD- 10 Diagnosis	Diagnosis list that are updated and added to yearly	http://www.apta.org/ICD10/?navID=10737433227 http://www.roadto10.org/quick-references/ Common list for your practice	October
National Correct Coding Initiative	Identifies what procedures can be billed together with a modifier and those procedures that cannot be billed together	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html	Annually /January
Functional Limitations (G codes)	Definitions of G codes that identify the functional limitation of a patient to be able to set goals	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/G-Codes-Chart-908924.pdf CMS Transmittal 2859-2014 G Code Update http://ww.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R2859CP https://www.cms.gov/Outreach-andEducation/Outreach/NPC/Downloads/FunctionalReportingNPC.pdf CMS Functional Limitation Reporting FAQS http://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/FunctionalReporting-PT-OT-SLP-Services-FAQ.pdf CMS Therapy Services http://www.cms.gov/Medicare/Billing/TherapyServices/index.htm	Annually