

Eli's REHAB REPORT™

The Practical Advisor on Reimbursement, Regulations & Business Strategies for Rehab Facilities

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BUSINESS STRATEGIES

Get Started on the Right Foot With Your Worker's Comp Patients

► *The first key steps can make the difference between bank and bust for these claims.*

Worker's comp cases can bring in great money — and keep that money flowing if you establish good business relationships with the employer. But getting reimbursed this way means you'll need to take important steps right from the start that you wouldn't do with regular health insurance claims. Ensure your coffers are flowing with the reimbursement you deserve with these strategies.

Treat the Patient With Respect

The best business move is not to make any assumptions or judgments when a worker's comp patient walks through your door. You may lose good business.

Mistake: "Unfortunately, many people classify worker's compensation cases as illegitimate or a sign of being lazy," notes **Barry G. Inglett, PT, CHT, Cert. MDT**, with Wayne Physical Therapy & Spine Center and Mailly & Inglett Consulting in Wayne N.J. "I have often had patients come to me that have gone to other facilities telling me that they were treated rudely by the physical therapist as well as other staff members."

Everyone deserves to be treated with dignity. And more often than not, the patients will work hard to resolve their problem and return to their previous job duties, Inglett observes.

Don't miss: Have the injured worker sign a release stating that you, the therapist, may share information regarding the worker's injury and any job restrictions with the employer, says **Bubba Klostermann OT, CVE/R, CEAS**, a worker's comp expert with West Texas Rehab in Abilene, Texas.

Get the Story Straight

With the release in hand, phone the patient's employer as soon as possible. "Ask to speak to the risk management or HR person," Klostermann advises. "Many workers won't know they were supposed to report the injury, and the employer might not even know the patient has had an accident."

Plus: The patient's story and the employer's story might not agree, "so you have to close that loop as well," Klostermann explains. For example, your

continued on next page

BUSINESS STRATEGIES, continued

patient may have told you he lifts a 150-pound object eight times a day, but the employer might reveal that the patient has access to lifts and hoists. Or, on the flip side, the patient might be doing more work than the employer realizes.

Do this: Once on the phone with the employer, get a job description for your patient. “Remember that the rationale for physical therapy with a worker’s compensation patient is always RTW (return to work) — not much else matters to the system,” says **Jim Dagostino, DPT, PT**, PTPN board member and owner of Dagostino Physical Therapy, a PTPN member office in Oceanside, Calif.

The job description will help you build the skeleton to your care plan. For more details on gathering a job description, see the “Clip and Save” following this article.

In addition to getting the job description, find out if the employer can offer your patient a modified duty so the patient can return to work as soon as safely possible. “Modified duty, in the past, referred to light duty,” Klostermann explains. “Getting back to work quicker has proven to save lost days and lost wages and save in overall medical costs as well.” Studies have also shown the

sooner an injured worker returns to work, the higher the chance of a successful case closure, he adds.

Finally, then tell the employer that you will update them regularly as to the progress of the injured worker and give them an idea of the time frame to complete the full process of closing the case, Klostermann recommends.

Snag Extra Income Opportunities

If you’re smart, you can rake in more than just your worker’s comp reimbursement for each case. When you’re on the phone with the employer getting a job description, ask if you may come onsite to do a job analysis. “Offer to go to the jobsite to measure and weigh things, to assess what the requirement of the job is, etc.,” Klostermann says.

What’s in it for you: “Cost for this service can range up to \$150 per hour,” Klostermann says.

Even if the employer doesn’t want a job analysis, be aware of the business opportunities in establishing a good relationship from the start. “If you handle things well, the employer may want to keep sending you their worker’s comp injuries — and they might also spread the work to their business colleagues,” Klostermann says. ■

BILLING

Use These Tips To Roll Your Worker’s Comp Claims in the Right Direction

► *Don’t treat worker’s comp like regular health insurance.*

Calling the employer of a worker’s comp patient involves more than getting a job description if you want to get paid. This is your window of time to gather the billing information you need to set your reimbursement in motion.

“The employer should tell you how to bill and who their insurer is,” says **Bubba Klostermann, OT, CVE/R, CEAS**, a worker’s comp expert with West Texas Rehab in Abilene, Texas.

But you should have a grasp on how the system works in case you have to track down lost dollars. Follow these tips to save time and money:

- **Don’t file the claim with just any payer.** “In most states, the law does not allow you to bill a private carrier or the patient unless you get a ruling from your worker’s comp commission that you’re dealing with a non work-related injury.”

- **Be aware of preauthorization requirements.** “In Texas, for example, everything has to be preauthorized to be reimbursed unless the treatment is two weeks within the

date of the injury or surgery,” Klostermann says. But even then, you should get the claim authorized, he suggests.

- **Know the claim could take one of several routes.** The employer could have worker’s compensation insurance or a private accident policy, but in some states employers can be “non-subscribers,” Klostermann points out. And if that’s the case, the provider must deal directly with the employer or their 3rd party administrator.

- **Keep track of your contacts and conversations.** In worker’s comp cases, you should be documenting much more than just the injury info and your rehab documentation. “Note any communication with the [worker’s comp] system — who you spoke to, what time, and what the conversation regarded,” emphasizes **Jim Dagostino, DPT, PT**, PTPN board member and owner of Dagostino Physical Therapy, a PTPN member office in Oceanside, Calif. “In California worker’s compensation [contacts] change, and the person who gave you authority may be gone. But when you have to follow-up you have more credibility.” ■

CLIP AND SAVE

Create a Crystal-Clear Job Description for Your Worker's Comp Cases

► *Open opportunities for an onsite work evaluation, too.*

You need your facts in line when you have a worker's comp case at your door. This worksheet will give you a solid starting point when you get on the phone with the patient's employer — and can squeeze in the chance to get you onsite as well.

JOB DESCRIPTION WORKSHEET

**TO BE COMPLETED BY THERAPIST BEFORE CONTACTING EMPLOYER;
IF PATIENT DOES NOT KNOW SOME ANSWERS, ASK EMPLOYER OR REP.**

PATIENT NAME: _____ DATE: _____

DATE OF INJURY: _____ DATE BEGAN THERAPY: _____

DIAGNOSIS: _____

THERAPIST: _____ PHYSICIAN: _____

SPECIAL THERAPY CONCERNS: _____

ANTICIPATED DATE OF RETURN TO WORK: _____ RESTRICTIONS? _____

EMPLOYER: _____ EMPLOYER PHONE: _____

SUPERVISOR'S NAME: _____ JOB TITLE: _____

IS PERSON WORKING NOW? Y N JOB: _____ HR/DAY _____

IF NO, IS THERE A JOB TO RETURN TO? Y N IF YES, WHAT? _____

IS MODIFIED DUTY AVAILABLE? Y N IF YES, WHAT? _____

ARE LIMITED HOURS ACCEPTED? Y N HOW MANY? _____

WHAT MODIFIED JOBS ARE AVAILABLE ? _____

IF AVAILABLE, FAX JOB DESCRIPTION, IF NOT, LIST REGULAR JOB DUTIES: _____

IF NO WRITTEN JOB DESCRIPTION IS AVAILABLE, WOULD A JOB SITE VISIT BY A THERAPIST TO DEVELOP ONE BE OF INTEREST? Y N WHAT TIME WOULD BE BETTER TO COMPLETE THIS? _____

COMPLETED BY: _____ DATE: _____

THERAPIST REVIEW: _____ DATE: _____

Source: West Texas Rehab, compliments of Bubba Klostermann, OT, CVE, CEAS. ■

IRFS

Crank Your Team Conference Quality Up a Notch

► *Updating your team conference documentation template can make all the difference.*

Having a rough ride with your team conferences since the new inpatient rehab facility coverage requirements went into effect? Catch the common bumps in the road now so you're not paying later when your claims go under the microscope.

Avoid These 5 Mistakes

Getting all your team members in the same place at the same time — and on time — is only the start. What you discuss, document, and decide for the patient is key to a successful case and successful reimbursement. But many IRFs are falling short. Some of the biggest issues consultant **Fran Fowler, FAAHC**, managing director of Health Dimensions Group in Atlanta, has noticed are:

1) Forgetting the big picture progress. Too many times, IRF team members use the conference to report where the patient is but not the progress the patient has made (or not made). And “CMS is looking for both the status *and* the progress of the patient,” Fowler says.

2) Misuse of FIM™ scores. “Teams often use FIM™ score numbers to document status with little regard to how the current functional level relates to the plan of care that is in the chart,” Fowler says.

3) Putting medical issues on the back burner. Frequently missing from the team conference note is how the patient's medical conditions are impacting his progress, Fowler points out. Likewise, the notes often fail to list ways in which the rehab team will address the medical issues and produce better progress.

4) Critical documentation voids. Many teams produce limited to no documentation that notes a change in plans to improve the patient's progress, Fowler notes. And similarly, teams often fail to document whether the plan of care is improving the patient's ability to function during activities of daily living.

5) Nursing and therapy disconnect. “Often team conference notes show no correlation between the nursing and therapy input,” Fowler says. And each team member can shed valuable light to one another that could change the course of a care plan.

Along the same lines, don't exclude your therapy assistants from the team conferences. Assistants cannot attend *in the place of* the therapists, but that doesn't mean assistants can't attend with the therapists. “The physician and the entire team benefit most from hearing directly from the person providing therapy on a daily basis,” says **Ann Lambert Kremer, OTR/L, MHSA, CPC**, with Beacon Rehab Solutions in Portland, Maine. “Also the assistants grow and improve by hearing input from the rest of the team.”

Give Your Form a Makeover

Don't let the laundry list of mistakes above get too overwhelming. A manageable remedy is revising the form you use to document your team conferences.

A good starting point is to change the name of your form from “team conference” to “integrated plan of care updates,” Fowler recommends. This gets everyone in the mindset of tracking progress and changes made instead of just describing the patient status.

Try this: Create a space to compare the information from the last team meeting to the current team meetings,” Fowler suggests. In addition, create an entry where you integrate the information presented by all disciplines, “as opposed to each discipline reporting on a different aspect of patient progress,” she adds.

Another idea: “Consider combining the team conference form with the interdisciplinary plan of care so that the plan of care is updated by the team on a weekly basis,” Kremer suggests. Just don't forget the 72-hour deadline for your first team conference.

Above all, make sure your new form documents

- progress towards the goals from conference to conference;
- barriers to discharge or progress (including medical) and how to address them;
- how the nursing plan of action dovetails with therapy; and
- changes needed to the plan of action to produce a usable outcome, Fowler says. ■

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Email Lindsey Rushmore, Editor, at RehabReport@gmail.com

BILLING

Make Time to Target Untimed Codes on Your Part B Therapy Claims

► **Don't let the RACs bilk you out of this one example of appropriate billing.**

RACs are already going after overbilling untimed therapy codes, so take a quick look to make sure your rehab organization isn't wide open for payment recoupments and related compliance woes.

Three out of four RACs have published untimed codes as an approved issue for automated review, warns **Nancy Beckley, MB, MBA, CHC**, a consultant with Bloomingdale Consulting Group Inc. in Brandon, Fla. Automated RAC reviews are ones "where the computer rolls away in the middle of the night and determines if a particular code has been billed in units of more than one."

In a nutshell: "An untimed code, according to the CPT code definition, is one billed irrespective of the time spent on the service," Beckley says.

In other words, if you don't see a time indicator, such as "15 minutes," "1 hour," etc. in the CPT code descriptor, you're looking at an untimed code.

Potential problem: "The therapy documentation may include the number of minutes," says **Victor Kintz, MBA, CHC, LNHA, RACCT, CCA**, managing director of operations for The Polaris Group based in Tampa, Fla. "But a biller who isn't familiar with the codes may bill for four units or an hour for an [untimed code]. And if the MAC or FI system pays it by mistake, then there's an overpayment," Kintz cautions.

So therapists in facility settings, especially, should alert their billers to this potential snag.

Know These Untimed Code Hot Buttons

Ouch: In the RAC demo alone, RACs recovered \$3.2 million on the issue of speech therapy untimed codes, noted **Betsy Anderson**, a VP at FR&R Healthcare Consulting in Deerfield Ill., in a presentation on RACs at the 2009 American Association of Homes & Services for the Aging annual meeting.

Speech-language pathology has the most commonly used untimed codes, Kintz notes.

"Speech/hearing therapy and swallowing therapy are examples of two."

Examples of untimed codes for physical therapy include electrical stimulation for stage III and IV ulcers

and paraffin bath therapy, Kintz adds. Also keep in mind that most rehab therapy evaluations are untimed codes — "no matter how long the evaluation took," he says.

The only exceptions are some timed evaluations for SLPs, such as 96105 (*Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour*) and 96125 (*Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report*) which are each a per hour code. OTs can report 96125 too.

Careful: It's not just the codes themselves you need to watch; modifiers can spring a RAC trap too. For example, "Medicare allows you to use the 59 modifier to identify situations where you provided therapy to more than one body site," says **Pauline Franko, PT**, principal of Encompass Consulting & Education in Tamarac, Fla. But you can't use a modifier 59 for an untimed code, she stresses.

Watch for Unfair RAC Denials

Even if you're following all the rules, beware mistakes on the RACs' end too.

Case in point: Some providers in Florida have had Part B therapy claims denied because claims had two untimed codes appearing on the same claim, Beckley points out. Yet "there is no prohibition against billing two untimed codes — the approved [RAC] issue is for two units of an untimed code," Beckley points out. And Florida providers are appealing those denials, she says.

An example of an acceptable claim "would be a speech swallowing evaluation and a speech swallowing service on the same claim," Beckley says.

And if your RAC comes after you for a claim like this, stand your ground and appeal. ■

Have a billing, coding, or compliance question? Send it to the editor at RehabReport@gmail.com.

CLINICAL REHAB ROUNDUP

Crank Up Your Assistive Technology Usage in the Schools

Effect of assistive technology in a public school setting. Watson AH, Ito M, Smith RO, Andersen LT. Am J Occup Ther. 2010 Jan-Feb;64(1):18-29.

The Individuals With Disabilities Education Improvement Act of 2004 (IDEA) requires therapists in the schools to consider assistive technology when planning special education students' individualized education programs (IEPs). IDEA also requires therapists to use the assistive technology based on peer-reviewed literature — even though the research on assistive technology's effectiveness in the public schools is scant.

The good news: Researchers just published a study conducted at Arlington Public Schools (Virginia) in the January/February 2010 issue of the *American Journal of Occupational Therapy* that explored assistive technology's effect in a public school education setting. And the study measure researchers used may be the key to effectively collecting assistive technology outcomes data.

The findings: Relative to other interventions, assistive technology provided by a multidisciplinary team of occupational therapy practitioners, speech-language pathologists, and educators may have a significant effect achieving positive outcomes indicated on IEPs for students in special education, announced a press release of the study from the American Occupational Therapy Association.

School-based occupational therapy is designed to enhance the student's ability to fully access and be successful in the learning environment. This may include the use of assistive technology, among other interventions, AOTA said.

"Assistive technology's contribution as an intervention strategy appears to be greater than nine other possible interventions — such as related services, tutoring, changes to the curriculum and student maturation — explored in the study," said **Anne H. Watson, PhD, OT/L**, an occupational therapist with Arlington Public Schools.

Researchers used as a study measure the Student Performance Profile (SPP), which the Rehabilitation Research Design and Disability Center developed originally for the Ohio Assistive Technology Infusion Project. This study used a modified, print version of the instrument written in conjunction with and approved by the original developers, AOTA said.

"The Student Performance Profile appears to have potential as an effective means of collecting assistive technology outcomes data in the public school setting," Watson told AOTA, naming advantages such as ease of administration, scoring, and customization. The instrument is also "sensitive to change in performance over time," Watson said. "An instrument with these characteristics may help special education staff pursue data collection regarding the effect of assistive technology on student performance." ■

READER QUESTIONS

Keep an Eye on the OT-SLP Crossover Zone

Question: *I have a speech-language pathologist who wants to bill for the following CPT codes:*

- 97532 (Development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact by the provider, each 15 minutes) *and*
- 97533 (Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct [one-on-one] patient contact by the provider, each 15 minutes).

Correct me if I'm wrong, but aren't these codes more appropriate for an occupational therapist to charge? I would like to give my SLP the go-ahead, but I don't want to bill inappropriately.

— Massachusetts subscriber

Answer: The American Medical Association develops CPT codes, and they do not apply to just one specific discipline. A health care practitioner can use any CPT code as long as he or she is qualified to do so. What makes one qualified is his education, training, state laws, and state practice act.

Insurance companies also determine which CPT codes they will cover and which discipline can provide the intervention and be reimbursed for it. For example, several Medicare contractors will reimburse for 97532 and 97533 if billed under a SLP POC, but you should check with your specific payer and with any private payer too.

Watch for: If your SLP has performed speech therapy reporting CPT 92507 (*Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual*) on the same day as reporting 97532, this code combo will flag a CCI edit, so be sure to document

continued on next page

READER QUESTIONS, continued

separate and distinct procedures and to append a Modifier 59 to 97532 on the claim form.

Know the Green Lights for Billing an Evaluation

Question: *I work in a private practice setting, and we just acquired a patient who was getting therapy for rotator cuff surgery at a different rehab facility, stopped rehab there, and two months later showed up at our practice to continue rehab.*

What does Medicare policy say about us doing a physical therapy evaluation? He's a new patient to us, but had a full evaluation and certification for physical therapy for the same diagnosis at the previous rehab facility. Does

Medicare limit us from billing a second evaluation for the same diagnosis?

— Wisconsin subscriber

Answer: No, Medicare policy does not limit you from billing a second evaluation for the same diagnosis in this situation. If you look at the definition of evaluation in CMS Pub 102, Chapter 15, Section 220, the Centers for Medicare & Medicaid Services states that an evaluation is warranted when the condition is treated in a new setting or for a new diagnosis. Your example would qualify as a new setting since you are a different provider. ■

NEWS BRIEFS

New Health Care Legislation Keeps Exceptions Hope Afloat

Got your sights on March 31 as your therapy cap exceptions expiration date? The monumental health care reform legislation, the Patient Protection and Affordable Care Act (HR 3590), passed mid-March and offers you more time.

“As a result of our advocacy efforts, HR 3590 contains several provisions that are consistent with APTA priorities,” wrote **R. Scott Ward, PT, PhD**, president of the American Physical Therapy Association, in a statement.

Those include:

- An extension of the therapy cap exceptions process through Dec. 31, 2010;
- An extension of the geographic practice cost index floor of 1.0 for 2010, which will help rural providers' reimbursement;
- Authorization of rehabilitation as a required minimum health care benefit as part of the health care insurance exchange; and
- Authorization of a study on different delivery models of physical therapy, including direct access under Medicare, according to Ward's statement.

Not so lucky: The 21.2 percent cut to Medicare Physician Fee Schedule payments slated for April 1, 2010, is still in effect. Your professional associations, however, are continuing to advocate for an extension of the 2009 Medicare pay rate.

RACs Get a Booster Shot From the White House

If Medicare's Recovery Audit Contractors (RACs) are raking you over the coals, get ready for more heat. President **Obama** has signed an executive order giving RACs more fuel. The executive order targets waste and fraud in Medicare, Medicaid, and other government programs, the White House reported in a press release.

The order praises the work of RACs, which receive financial incentives to find improper payments. RACs “have been demonstrated through pilot programs to be highly effective,” the White House cheers. “In fact, expanded use of payment recapture audits could return at least \$2 billion in taxpayer money over the next three years — double the current amount of projected recovered costs.”

In addition, the president signed a presidential memorandum on March 10 that directs all federal departments and agencies to expand and intensify their use of payment recapture audits.

The president specifically named the RAC pilot “successes” in California and New York in his remarks on health insurance reform in St. Charles, Mo, reports *News Now*.

Obama also supports the Improper Payments Elimination and Recovery Act bipartisan legislation, which expands government agencies' ability to fund the audits with recaptured payments.

To view the full press release and fact sheet regarding this executive order, visit www.whitehouse.gov/the-press-office.

continued on next page

NEWS BRIEFS, continued

MedPAC Puts In-Office Ancillary Exception Under the Microscope

Expect head-butting between therapists who work for physicians and therapists against physician-owned therapy services.

The Medicare Payment Advisory Commission (MedPAC) recently heard a report on incident-to services and discussed services provided under the in-office ancillary exception to the physician self-referral law, according to *News Now*. The report addressed the potential abuse of in-office ancillary services, including physical therapy, radiation therapy, diagnostic imaging, and laboratory testing.

The report also noted an increase in spending from \$1.4 billion to \$2.2 billion between 2003 and 2008, as well as a shift in distribution of the spending across therapy services furnished incident to, physical therapy services in private practice settings, and occupational therapy services in private practice settings.

And APTA has its eye on these numbers. The Association believes that physical therapy should not qualify as a designated health service under the in-office ancillary service option, and plans to stay in close contact with MedPAC regarding this issue, *News Now* reports.

Meanwhile, MedPAC released its March 2010 Medicare Payment Policy report to Congress on Medicare fee-for-service reimbursements. The 2011 recommendations include:

- A zero update for skilled nursing facilities and inpatient rehabilitation facilities.
- Nixing the home health market basket update for 2011 and re-basing rates for services to reflect the average cost of providing care.
- Increasing payment rates for hospital acute inpatient and outpatient prospective payment systems by the projected rate of increase in the hospital market basket index, along with a quality incentive payment program.

To see a fact sheet on MedPAC's report, visit http://medpac.gov/documents/Mar10_FactSheet.pdf. ■

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