DOWNLOAD PDF INPATIENT PHYSICAL THERAPY POLICY PROCEDURE MANUAL

Chapter 1 : The Rehab Center : HIPAA Policies and Procedures Manual

The policy and procedure manual plays an important role in every business and organization, and physical therapy is no exception. The development and enforcement of policies and procedures is an important responsibility of physical therapist (PT) managers.

Info for Payers Concerns have been raised regarding the delivery of outpatient physical therapy services, specifically regarding the appropriate use of one-on-one codes as opposed to the group code. This page should not be construed as legal advice. The contents are intended for general informational purposes only, and readers are urged to consult their own legal counsel with regard to their own specific circumstances. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services. The physical medicine and rehabilitation CPT codes are classified as evaluation codes, supervised modalities, constant attendance modalities, therapeutic procedures, and tests and measures. The descriptive language accompanying most of the therapeutic procedure codes requires that the "physician or therapist have direct one-on-one patient contact. Language describing the appropriate use of one-on-one codes and the group code under the Medicare program first appeared in the Federal Register in , Vol 59, No , p. The same language was republished in the Federal Register in , Vol 61, No , p The language in the transmittal states: Group Therapy Services Code Pay for outpatient physical therapy services which includes speech-language pathology services and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required. In one case, the physical therapist, or physical therapist assistant under the direction and supervision of a physical therapist, is simultaneously treating two or more patients whose conditions or treatment have a common, unifying element. For example, the patients might all have had knee surgery; or they might all benefit from specific types of pool exercises; or they might all be part of a class for people waiting to be fitted for lower limb prostheses. The physical therapist might provide some introductory instruction and would remain in attendance for the duration of the session for which a group code was billed. In another scenario, patients could have diverse conditions and be receiving diverse treatments as part of a group to which the physical therapist gives constant attendance and provides differing, but skilled, services in accord with his or her professional judgment. APTA recognizes that in the above situations it may be possible to add the time spent with each individual patient and bill for these services with an appropriate one-on-one code when the one-on-one time requirements are met. This also may be the most efficient approach. However, APTA also supports the interpretation that would allow these professional services to be billed under the group code, which is an untimed code, all other requirements for professional services having been met. The duration of the group session to which the code is applied should be sufficient to ensure that professional "skilled" services are provided. CMS has established a correct coding initiative edit that prohibits billing for group therapy along with certain therapeutic procedure CPT codes , , , , , , in the same session unless a â€”59 modifier is used in certain settings. To be reimbursed for both services, the providers documentation must support that the group therapy and the therapeutic procedure were performed during separate time intervals. Lastly, APTA does not interpret Transmittal as prohibiting payment for a supervised unattended modality and a one-on-one service being delivered to two patients in the same time interval. For example, Patient A is receiving unattended electrical stimulation at the same time as patient B is receiving therapeutic exercise. Patient Care Scenarios Assumptions: These scenarios involve Medicare patients, unless otherwise stated. These scenarios could only be applied if consistent with state law in the state in which they are being applied. According to Medicare regulations, a qualified physical therapist practitioner is a person who is licensed as a physical therapist by the State in which practicing, and who has graduated from a physical therapy curriculum approved by: These regulations also identify criteria for individuals

educated as physical therapists before , or who were educated outside the United States. APTA defines a physical therapist as a person who is a graduate of an accredited physical therapist education program and is licensed to practice physical therapy. The terms "physical therapist" and "physiotherapist" are synonymous. According to Medicare regulations, a qualified physical therapist assistant is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and 1 Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or 2 Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, [42CFR The APTA defines a physical therapist assistant as a technically educated health care provider who assists the physical therapist in the provision of physical therapy interventions. The physical therapist assistant, under the direction and supervision of the physical therapist, is the only paraprofessional specifically educated to provide physical therapy interventions. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program accredited by the Commission on Accreditation in Physical Therapy CAPTE. APTA defines physical therapy aides as any support personnel who perform designated tasks related to the operation of the physical therapy service. Tasks are those activities that do not require the clinical decision making of the physical therapist or the clinical problem solving of the physical therapist assistant. Medicare regulations require "personal" meaning in-room supervision of PTAs furnishing services in private therapist practices. Medicare requires "general" supervision meaning periodic inspection and PT availability by telecommunication of PTAs furnishing services in skilled nursing facilities SNF , comprehensive outpatient rehabilitation facilities, certified rehabilitation agencies, and home health agencies. Direct supervision meaning on-premises is required in physician practices. If states have more stringent PTA supervision regulations than Medicare, then providers must follow state regulations when furnishing services to Medicare beneficiaries. These are intended to be examples of proper coding for billing purposes They are not intended to establish a standard for clinical practice. The physical therapist is one on one with Patient A from 9: The time that Patient B spends with the physical therapist assistant from 9: In addition, the time spent with the physical therapist from 9: It is appropriate to bill 2 units of gait training rather than 3 units, because there were interruptions during the time frame. Patient B arrives for a 9: The physical therapist determines that an ultrasound is appropriate to begin the treatment. The physical therapist examines the area to be treated, and directs the physical therapist assistant to position the patient and apply the ultrasound. Patient A leaves the clinic at 9: The physical therapist assesses the patient following the application of ultrasound and begins a manual therapy technique to the area. Patient A received three units of therapeutic exercise Patient A received two units of therapeutic exercise from 8: Patient B then receives manual therapy from 9: Patient B then receives therapeutic exercise from 9: Patient C receives 30 minutes of therapeutic exercise , which amounts to two units. They have all recently been fitted with lower limb prostheses. Patients A, B and C are below-knee amputees and patient D is an above-knee amputee. The physical therapist performs ADL training, including stump management techniques with these four patients for 60 minutes. During this 60 minute session, each of the four patients performs return demonstration of the techniques they are instructed in individually for approximately minutes each , with the therapist, one to one, to ensure compliance with the techniques in their home settings. Patient A, B, C, and D would be considered as a group with a common, unifying element, therefore a group code would be billed for each patient. According to Program Memorandum, AB, the duration would be appropriate to bill one on one codes. All four patients have arthritis. The physical therapist performs a total of 55 minutes of group exercise with these four individuals, allowing for a 5- minute rest after the first 20 minutes of continuous exercise. During the rest period the patients self-monitor their heart rates as they return to resting and compare their findings to previous sessions. The session ends with the therapist reminding patients to continue to perform their land-based home exercise programs. This is a group with a

common unifying element arthritis. The patients do not receive one-on-one treatment; therefore it is appropriate only to bill the group Group Combined with Modalities and One-to-One a. Patients A, B, C are scheduled for physical therapy at 9: Patient A is being seen for a recent shoulder dislocation. Patients B and C are both recovering from rotator cuff surgery. Periodically the physical therapist will provide verbal cues to patients B and C to assure correct position and speed of their exercises. Their visits all end at The therapist is providing skilled services to all 3, while in constant attendance. Therefore, a group therapy code would be billed for each patient. During that time frame, the physical therapist periodically looks up and makes comments to B and C; however, this time is not counted as billable for B and C, because the therapist is still attending to patient A with his hands during this brief encounter with patients B and C. Patient A is receiving ice during this time frame which is not a billable service under the Medicare program. Patient C is receiving unattended electrical stimulation , which is billable as it does not have to be one-on-one. The time that patient A and B spend performing the upper body ergometer is not billable, because the physical therapist is conducting the home program with patient C. This scenario differs from 5a in that there is no group charge. The physical therapist would not bill group because there is not the initial 20 minutes with all three patients that occurred in scenario 5a. Patient A receives shoulder stabilization exercise techniques from approximately 9: Periodically, the patient provides verbal cues to patients B and C. However, the time of patient B and C is not billed as either group or one-on-one, because the therapist is working one on one with Patient A. During this time frame, Patient A is receiving ice, which is not a billable service under the Medicare program, while Patient C is receiving unattended electrical stimulation , which is billable, because it is not a one-on-one code. However, the 10 minutes spent by A and B performing upper body ergometer is not billable as it is not supervised. Aggregate Time Patient A arrives for their physical therapy appointment at 9: The plan of care is currently focused on the patients need for balance training due to vestibular problems. The physical therapist performs 25 minutes of balance exercises with patient A. The patient rests for 5 minutes. Patient B has arrived for his appointment at 9: Patient B, who is being seen for complaints of back pain is seen by the physical therapist initially for 5 minutes of stretching to a tight hamstring. The Therapist provides alternating one to one interventions to both patients A and B for 15 minutes by moving between patients as they progress through their exercises. By 10 AM patient A had received a total of 48 minutes of one-on-one therapeutic interventions, Patient B had received a total of 12 minutes of one-on-one therapeutic interventions. The therapist takes a break to see patient B and then moves back and spends more time with Patient A. Neither patient A nor patient B receives group. The one on one time spent alternating back and forth between A and B is incremental and aggregated.

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Chapter 2 : CPT Codes and Physical Therapy: What You Need To Know | WebPT

Description MCN Healthcare's Rehabilitation Services Policy and Procedure Manual contains Physical Therapy, Occupational Therapy and Speech-Language Pathology policies as they relate to CMS regulations and Joint Commission, NIAHO and CIHQ standards for acute care.

As mentioned in the intro above, while CPT codes are similar to ICD codes in that they both communicate uniform information about medical services and procedures, CPT codes identify services rendered rather than diagnoses. Then, you might complete standard canalith repositioning on your patient, in which case you would include CPT procedural code on your claim. What is Modifier 59? How Do I Use It? The CPT Manual defines modifier 59 as the following: However, when another already established modifier is appropriate, it should be used rather than modifier Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. So, how does modifier 59 come into play in the therapy setting? This, in turn, determines whether modifier 59 is appropriate. According to NCCI, the following are considered linked services when billed in combination with Medicare actually uses this example on its site to explain appropriate use of modifier 59 among rehab therapists. CMS states that when billing and therapeutic activities; direct, one-on-one patient contact by the provider; or use of dynamic activities to improve functional performance, each for 15 minutes for the same session or date, modifier 59 is only appropriate if the therapist performs the two procedures in distinctly different minute intervals. This means that you cannot report the two codes together if you performed them during the same minute time interval. If the care you provide meets the appropriate criteria, you can add modifier 59 to to indicate it was a separate service and should be payable in addition to the The same holds true for billing with , , , , , , or However, you can never bill with â€”and you cannot add any modifier to change this restriction, because these codes are mutually exclusive procedures, according to CMS. When Should I Use Modifier 59? Therefore, we recommend asking the following questions to decide if and when you should use modifier Are you billing for two services that form an NCCI edit pair? Recognizing those instances, though, requires you to recognize NCCI edit pairs. To make a long story short, edit pairsâ€”also called linked servicesâ€”are sets of procedures that therapists commonly perform together. Did you perform those two services separately and independently of one another? Basically, when you append modifier 59 to one of the CPT codes in an edit pair, it signals to the payer that you provided both services in the pair separately and independently of one anotherâ€”meaning that you also should receive separate payment for each procedure. Does your documentation support your assertion that you performed the two services separately and independently of one another? That means you should never: Doing so could throw up a red flag to your payers. Is a more descriptive modifier available? Clinicians, coders, and billers should only use modifier 59 as a last resort i. However, even though these modifiers went into effect January 1, , the APTA has stated that therapists do not need to start using them in place of modifier 59â€”at least not yet. That being said, therapists may be required to use the new modifiers in the future, so keep an eyeâ€”or an earâ€”out for further instruction regarding modifier 59 usage. Download your modifier 59 decision chart. Please enable JavaScript to submit form. Look for the primary CPT code you are billing in Column 1. If you are billing any of the codes listed, they will be considered mutually exclusive or linked. Note that this is the CCI edit list from Medicare. Most government payersâ€”like Medicare, Tricare, and Medicaidâ€”use this same list. However, private payers often create their own edit pairs; therefore, there is no guarantee they will pay, even with an applied modifier Want the below table in a printable, easy-to-reference PDF?

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1.A Page 1 of 1 R: 3/01 Cochise Regional Hospital Physical Therapy Policies and Procedures Physical Therapy Care

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and Services POLICY The Physical Therapy Department is one of the professional service departments of.

Chapter 4 : Inpatient Physical Therapy | Augusta Health

POLICIES AND PROCEDURES MANUAL RESTORE Physical Therapy was founded in by Steven L. The policies and procedures in this manual are not intended to be.

Chapter 5 : Institutional Handbook of Operating Procedures (IHOP) | TOC

Physical Therapy Department Policies and Procedures Manual Revised April Department of Physical Therapy Berrien Springs, Michigan

Chapter 6 : Outpatient Rehabilitation Policy and Procedure Manual

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Chapter 7 : Rehabilitation Services Policy and Procedure Manual

"inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital.

Chapter 8 : Inpatient Rehabilitation

Inpatient Assessments Record Retention Policy APPENDIX J Therapy Room Assignment Book (TRAB) CHP Clinic Policy and Procedure Manual.

Chapter 9 : Joanne Whipple (Author of Outpatient Physical Therapy Policy & Procedure Manual)

on other Conditions; e.g., physical therapy services (Â§), speech pathology services (Â§), rehabilitation program (Â§), and physical environment (Â§). Review the licenses to assure the licenses are current and are applicable to the State in.