

## Documentation and Billing: What is the Regulatory Board's Role?

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**A**pplication of published coding and documentation guidelines, whether it be those which a practice or facility develops in context of their clinical and payer environment or those which a third party payer develops and requires to be followed by providers of services to their beneficiary's, can have a huge impact not only on timely and appropriate payment but on the ability to achieve this in a compliant manner as to avoid action by the states regulatory board.

The following case study was presented at the Federation of State Boards of Physical Therapy Annual Meeting in September of 2008:

*A licensee directs a physical therapy aide to perform or supervise therapeutic exercise with a Medicare patient. The licensee documents and bills Medicare for therapeutic exercise performed by therapy aide using CPT code 97110 (Therapeutic Exercise). The patient complains about care that was provided to them at a physical therapist's practice, stating they felt care was provided by unlicensed personnel. Upon review, the licensing board*

*has jurisdiction and accepts the complaint. An investigation identifies the following relevant issues:*

- *Review of documentation reveals illegible notes, lack of discharge summary, and lack of clinical justification for services provided.*
- *Review of the clinic schedule at the time complainant was being seen identified that typically two to three other patients were scheduled during the same hour*
- *Review of charges for complainant visits identified patient was typically charged 4 units of 97110 (therapeutic exercise) each visit.*

Aspects of this scenario may seem familiar. Similar situations are occurring with alarming regularity and are actually finding their way to licensing boards' agendas, even as audits and reviews of physical therapy services are also increasing at alarming rates. In addition, as we review the various proposals for healthcare reform currently being debated, one thing is clear – efforts to reduce fraud, waste, and abuse in the Medicare program are consistently referenced as an important vehicle to capture dollars to fund the proposed effort.

The Mission of the Rehabilitation Consulting and Resource Institute (RCRI) is to educate and train providers in the areas of practice management and payment policy, as well as facilitate appropriate payment policy by third party payers as it applies to rehabilitation services across all outpatient settings. RCRI's goal is to facilitate a more strategic approach to the delivery of and payment for rehabilitation services, while maintaining compliance with coding, billing, documentation, and regulatory requirements as well as professional standards and guidelines governing the provision of outpatient therapy services.

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The following definitions of fraud and abuse are important to review as they may impact potential penalties in the event of a payer review, or a regulating body investigation.

## Fraud

**Fraud** is defined by one who **knowingly** and **willfully** executes, or attempts to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

## Abuse

In contrast, **abuse** is defined by that which may **directly** or **indirectly** result in unnecessary costs to the Medicare or Medicaid program, improper payment, or payment for services which fail to meet professionally recognized standards of care or that are medically unnecessary.

Abuse involves payment for items or services when there is no legal entitlement to that payment and the **provider has not knowingly and/or intentionally misrepresented facts to obtain payment**. These definitions are important to understand, as they impact whether criminal or civil charges would be filed if a therapist is found to be guilty of non-compliance with established laws or regulations.

The following key compliance issues are typically found to be relevant to physical therapist practice:

- Submitting claims for services that are not medically necessary
- Billing for services not provided/documented
- Unbundling and upcoding
- Documentation does not support the units of timed services billed
- Inappropriate use of personnel
- Misuse of provider identification numbers
- Care provided that is below the accepted standards
- Routinely waiving copays/deductibles

Medicare is often used as a standard from which to develop practice/facility policies and procedures. While Medicare's

rules and regulations should not be universally adopted, they do provide a place to start in the review and discussion of issues involved in complaints to regulatory boards. Often-times third party payers will adopt Medicare policy as their own because of the transparent nature of the Medicare program's guidance and because they do not have the resources/knowledge to develop their own standards for supervision, documentation, and coding. Sometimes, especially for the smaller insurer, it simply avoids "reinventing the wheel." While therapists do not always agree with this approach, it does provide a basis of common knowledge and understanding from which both payers and providers can begin their policy discussions.

## Four Issues

There are four issues which are routinely the focus of audits and investigations. Physical therapy regulatory boards should be particularly familiar with these issues in today's healthcare environment:

1. Third party supervision requirements
2. Appropriate coding for services with respect to the use of "direct contact" CPT codes
3. The reporting (and billing) for timed treatment
4. The adherence to documentation requirements

## Third party supervision requirements

In regards to supervision, although many state laws allow for offsite supervision of the physical therapist assistant, some payment policy will differ from state practice acts. For example, Medicare requires that beneficiaries seen in the hospital OP rehab setting by a PT assistant be supervised under those requirements outlined in the state practice act (statute and rules). But the private practice setting under Medicare (or PTIP) requires onsite direct supervision of physical therapist assistants. When a complaint comes before a licensing board that involves the issue of supervision, in addition to being reviewed from the perspective of statute and rules, it also should be reviewed from the perspective of specific payment policy or provider contractual language that the licensee agreed to adhere to, which may be stricter than that state statutes or regulations.

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## Appropriate coding for services with respect to the use of “direct contact” CPT codes

CPT codes are typically required to describe clinical services provided to a patient. They assist a third party in identifying the service provided. The amount of money paid for that service is then reflected in the claims payment. There are many payment methodologies: payment by “a fee for service” and therefore by CPT code; bundling services (as described by CPT codes) together and paying one fee for several related services; paying a negotiated rate for an episode of care based on the patient's diagnosis or other classification determined by the payer (case rate); or a capitated rate that is typically a per member per month rate paid regardless of the types of services provided or CPT codes reported.

Some payers' CPT codes nomenclature is copyrighted and only their payment policy can specifically describe interpretation of this code language in terms of payment. When billing a third party using copyrighted nomenclature for CPT codes, payers expect to see their code's descriptive language in billing documentation.

If there is no specific payer “policy” for the code billed, then the language of the code would stand on its own in terms of the need to reflect in documentation the time and the clinical content of the service.

Other CPT code language that the payer may have a specific policy on is the language describing that the “physician or therapist is required to have direct (one on one) contact.” Whether or not a physical therapists in this case believes these services described under this heading need to be provided in this manner, they should document to reflect that the service described by the CPT code was delivered to the patient in the manner described, again allowing for the payer, through their stated payment policies, to require something in addition to or less than what the code describes.

## Reporting (and billing) for timed treatment

The future may bring instructive language regarding the reporting of time as included in certain CPT codes, but for

now, typically, at least half of the time identified in the published code descriptor is what is expected by many payers in order to be able to report the code. Some payers may have different policy, which is under their purview to do. For example, Medicare instruction requires at least 8 minutes of a timed code in order to report the service, but then asks providers to document total treatment time and how much of that time was spent providing “timed code” services, and then to code accordingly.

## Documentation Requirements

The fourth area discussed in the context of this article is adherence to documentation requirements that may be required by third parties, based on professional guidelines or requirements of state practice acts. For example, Medicare's Minimal Documentation Requirements, published in the Medicare Benefit Policy Manual Chapter 15, sections 220-230, detail that, at a minimum, documentation of an initial evaluation, treatment notes, progress notes, and discharge notes, all with specific requirements, be present in the medical record, justify medical necessity, and support the CPT codes submitted for payment purposes. Other third party payers may have their own guidelines related to their benefit, follow Medicare guidance, defer to practice act, or simply stay silent. Lack of adequate documentation is one of the most common findings when a complaint leads to a review of the clinical documentation.

## Compliance Plans

The licensing board can play an effective role in providing, recommending, or requiring therapists to improve their current understanding and adherence to rules and regulations that govern the practice of physical therapy. *Compliance Plans* are one tool that are best used proactively to avoid or limit liability and provides for description of Standards of Conduct for a facility or practice.

The benefits of a Compliance Plan include:

- Effective internal controls to assure compliance
- Accurate assessment of employee and contractor behaviors relating to fraud and abuse
- Improvement of the quality, efficiency, and consistency

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- of providing services
- A centralized source for distributing information on healthcare statutes, regulations, policies, and other program directives regarding fraud and abuse and related issues
- A methodology that encourages employees to report potential problems
- Procedures that allow prompt, thorough investigation of alleged misconduct by members of a company
- Facilitation for the initiation of immediate, appropriate, and decisive corrective action

### Corrective Action Plans

*Corrective Action Plans* are another valuable tool in assisting therapists to become compliant with rules and regulations. They are best used following assessment of areas of risk, and identify areas of risk or potential exposure related to compliance with technical requirements (statutory or regulatory) as well ensuring ongoing compliance with existing or future requirements. The benefits of a Corrective Action Plan include:

- Provides clear direction to achieve compliance with technical requirements and professional standards
- Provides evidence to government agencies, regulatory boards, third party review organizations, and others of facility/practitioner efforts to achieve and maintain compliance
- Provides practice/facility benchmarks to continually assess success in meeting compliance goals

### Sample Recommendations of a Corrective Action Plan

might include the following:

- Education and training in the following areas:
  - Minimum documentation requirements of relevant third party (i.e. Medicare, Medicaid)

- Intent and application of relevant CPT codes
- Appropriate documentation and billing of time-based, direct one-to-one procedures
- Appropriate understanding of concept of medical necessity and justification for documentation based on third party requirements
- Development and documentation of functional goals
- Coding and documentation audits in order to ensure compliance with third party or regulatory requirements
- Fee schedule assessment to ensure appropriateness of charges for services provided
- Review of current staffing ratio/patterns to facilitate effective use of physical therapy personnel while ensuring compliance with third party and regulatory requirements
- Development of self assessment/internal audit processes

Serving on a regulatory board as a licensed physical therapist or physical therapist assistant is an opportunity to bring all aspects of practice into focus to review a complaint in the context of statute and law. Serving on a regulatory board as a public member presents the challenge of understanding all aspects of a case as it applies to the practice of a physical therapist or physical therapist assistant with not only the perspective of practice, but also perhaps from the viewpoint of the public's interaction with the licensee. Both the licensee who has a complaint filed against their license and the member of the public who is affected by the specific facts of the case are best served by a board member who has the information regarding these key areas of compliance as a part of their available resources and references.