Knowledge of correct coding and documentation for therapy reimbursement is critical to the bottom line of any wheelchair and seating clinic. The challenges we face seem to constantly change. The first step is familiarity with the Current Procedural Terminology (CPT) and how to use these codes for the services provided. And secondly to document the skilled services provided in a concise and timely fashion and obtain signed certifications from the referring physician. Other challenges include Multiple Procedure Payment Reduction (MPPR), Medicare Therapy Cap, Functional Limitation Reporting, and obtaining Prior Authorization from insurance companies.

CarePartners Health Services has structured our outpatient seating clinic to address all of these challenges and to see as many patients as we can in one day without sacrificing quality of care. Our Seating Clinic is fortunate to be a part of a not-for-profit, post acute care facility that is made up of an 80 bed inpatient rehabilitation hospital, Home Health Agency, Hospice, Adult Day Care and Outpatient facility located on the main campus, plus 4 satellite clinics. However, we still struggle to maximize our reimbursement. This article is intended to provide you with some guidelines, but I am by no means an expert in this area, just trying to share the highlights of what I have learned over the years. I highly recommend you attend courses offered by APTA, AOTA or CIAO Seminars (www.ciaoseminars.com) to learn the finer details.

CPT CODES
CPT is a trademark of the American Medical Association and may be service based (untimed) such as an evaluation code (97001 or 97003) or time-based such as wheelchair management (97542). These two codes are the most commonly used codes for the first visit in a wheelchair clinic. They may be billed on the same day without the use of a distinct procedural service modifier, 59. An evaluation includes review of the patients’ medical history, current status and functional abilities, environment and transportation issues related to wheelchair use, and discussion regarding their goals to develop your plan of care. An evaluation is required prior to providing therapy. All therapeutic procedures require one-on-one contact for the application of clinical skills and/or services that attempt to improve function. Some of the procedures require an evaluation be completed on one day with referral to complete the other service on a subsequent day, such as Physical Performance Test or Measurement (97750) or Assistive Technology Assessment (97755). These 2 codes are considered to be mutually exclusive and will not be reimbursed if both are rendered by the same provider on the same day of service or if either is provided on the same day as an evaluation. In addition the provision of 97542 on
the same day of service as 97755 is a column 1/column 2 edit and requires the use of the 59 modifier and your documentation must support the fact that these services were provided at distinctly different 15 minute intervals. Please refer to the attached chart for reference to some of the other Correct Coding Initiative (CCI) Edits

“8 MINUTE RULE”
Speaking of 15 minute intervals, another important guideline is the “8 minute rule”. For any single timed CPT code, you may bill a single 15 minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. When the duration of a procedure is greater than or equal to 23 minutes through and including 37 minutes, 2 units should be billed. If a timed service is performed for 7 minutes or less on the same day as another timed service that was also performed for 7 minutes or less, then bill for one unit for the service performed for the most minutes. The same applies to longer periods of time. Example: 24 minutes of 97760 (orthotic management) and 23 minutes of 97542 (wheelchair management) for a total of 47 minutes = 3 units billed, 2 of 97760 and 1 of 97542.

CODE DESCRIPTIONS
Descriptions of each of the therapeutic procedures can be found in AMA publications (https://catalog.ama-assn.org/catalog/cpt/issue_search.jsp). Below are a few of the commonly used codes. In bold is the description of each code from AMA and suggestions regarding the use of each code. I strongly recommend referencing your PT/OT Local Coverage Determination regarding criteria for provision of these services.

97112 Therapeutic Procedure, neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, each 15 minutes. May be utilized for seating and access intervention that includes assessing, training, facilitating to improve postural stability, motor control, motor learning, neuromuscular balance and/or access issues.

97542 Wheelchair Management (assessment, fitting, training), each 15 minutes. This "includes assessing if the patient/client needs a wheelchair, determining what kind of wheelchair is appropriate, including its size and components, measuring the patient/client to ensure proper fit, and fitting the patient/client into the chair once it is received. This code is also used for reporting the time associated with training the patient/client and/or caregiver in transfers in and out of the chair as well as propulsion on all surfaces. It is important for the therapist to provide instructions for safety so as not to risk skin breakdown or a fall."
(NC LCD for Outpatient PT: L31581)

97750 Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes. Utilized for functional performance tests to assess needs and identify problems. Document the specific test used, describe the data collected and the implication on the patient’s plan of care, as well as decisions made based on the results. Examples include Timed Up and Go, Tinetti, Pressure Mapping.
97755 Assistive Technology Assessment (eg, to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes. May be used to assess the technology interface for persons with multiple technology requirements or significant physical impairments that require identification of alternative controllers and system integration.

97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s), and/or trunk), each 15 minutes. May be utilized for interventions involving custom molding and fitting of custom molded seating systems, as well as training the patient/caregivers on fit and functional use.

PLAN OF CARE (POC)
As previously stated your documentation must state the skilled services provided and the certification for your plan of care must be signed by the physician prior to billing for any treatment provision. The 700 forms and 701 forms may be utilized or you may modify your own form as long as the necessary components are included such as diagnosis, date of onset, start and end dates for your services, summary of your evaluation, objective measurable goals, frequency and duration of services and specific treatment planned.

MEDICARE MPPR
The Medicare MPPR Rating went into effect January 1, 2011 but only applies to the Practice Expense (PE) portion of each code. The Relative Value Unit (RVU) of CPT codes has three components: Work, PE and Malpractice costs. The reduction in the PE payment for each additional code billed on the same day of service increased to 50% beginning April 1, 2013. This reduction means about a $5.00 reduction in reimbursement for each additional 15 minute unit of service provided after the first unit.

MEDICARE CAP
The Medicare Cap rule went into affect for all Part B outpatient services this past year. For 2013 the therapy cap amount was set at $1900 for OT and $1900 for PT and Speech therapy combined. The exceptions process was extended for one more year. Recipients still pay their deductible of $147 and 20% of the $1900. For a patient to qualify for the cap exception, the services must be medically necessary and documented. Currently there is no pre approval process for Medicare Contractors and a Manual Medical Review will be conducted when the $3,700 threshold is reached. A KX modifier must be added when a code that is subject to the therapy cap limit is billed when the patient qualifies for the cap exception. Keeping track of the amount each recipient has used is challenging, so make sure your access staff has a method set up to help you manage this process.

FUNCTIONAL LIMITATION REPORTING
Medicare Functional Limitation Reporting is required beginning July 1, 2013. Therapists must submit information on the claim forms to capture data on the patient’s functional limitations at the time of the evaluation, re-evaluation, minimum of 10th visit, changing of
primary limitation and at the time of discharge. Therefore at the time of evaluation a G code must be selected and a modifier selected for current status and projected goal. When the patient is discharged the same G code is reported along with the modifier at time of discharge. The modifiers indicate the patient’s percent of impairment, limitation or restriction. There are 7 levels ranging from 0 percent impaired to 100 percent impaired. Documentation in the medical record must support the modifier selected and how it was selected. This may be done through the use of an objective, measurable standardized test or by the therapist using his/her clinical judgment based on multiple tools used during the evaluation process. For a one time visit, all three statuses may be reported with the same modifier. For someone that you expect no change in functional limitation, such as someone you are seeing for a replacement wheelchair, or you evaluate and recommend a chair that the supplier will deliver without therapist, the G code for Other PT/OT Primary Functional Limitation may be appropriate with the CH modifier, which means 0 percent impaired, limited or restricted. However, the provision of a new wheelchair often does make a change in the user’s functional mobility or posture and therefore you may choose to use the G-code for Walking and Moving Around or Changing & Maintaining Body Position. There is not a specific test identified for the purpose of selecting the modifier, therefore therapists may choose which test(s) to use.

**PRIOR AUTHORIZATION**

Other recommendations for your clinic include having access staff obtain prior authorization from private insurance companies and check to make sure the individual policy covers the codes you might use. We utilize an Insurance Verification and PA Form which includes verifying if CarePartners is a preferred provider, amount of deductible, co-insurance or OOP met for the year, visit limitations and how many visits have been used. I also recommend you confirm the coverage available from your state Medicaid program. NC Medicaid has a limitation of one therapy evaluation and 3 visits for all disciplines combined per calendar year for adults 21 years old and older. Prior authorization is required for treatment services and must be submitted online by the treating therapist. The required information is similar to the Medicare POC.

**APPEALS AND REIMBURSEMENT**

On a final note, it is important to appeal denials in a timely manner. This requires having open communication with your business office so that you are informed and provided with the documented reasons so you can complete the appeal by the deadline. Another one of the most difficult issues we have had is finding out the actual amount reimbursed per visit for our patients. This is an ongoing concern that we continue to address. We did find out years ago that we receive improved reimbursement when we provide an evaluation on the first visit and schedule a second visit for continued assessment to complete our recommendations at which time we bill therapeutic codes as appropriate. This is especially true for many private insurance companies which reimburse for only one hour of treatment per visit.

**CONCLUSION**

The suggestions and guidelines provided above are based on our experience and courses attended over the years. They are guidelines only and I highly recommend each clinic to
review the LCD for your area and inquire about the interpretation of the codes you plan to utilize.

References:
American Medical Association *Current Procedural Terminology; CPT 2012; Standard Edition*

Outpatient Therapy CPT Coding, Billing & Documentation for Rehabilitation Reimbursement; Course Instructor Rick Gawenda, PT

New Functional Limitation Reporting Requirements, Heather L Smith, PT, MPH; APTA PT in Motion, March 2013, pgs 42-45

Medicare Therapy Services:
http://www.cms.gov/Medicare/Billing/TherapyServices/index.html?redirect=/TherapyServices/


To locate an LCD: