AOTA Reimbursement and Regulatory Policy Department
Advocate for the Profession
- CMS and its Contractors
- Private Insurers
- Physicians and Non-physician Practitioners

Provide Education and Communicate
- Payers
- Government Agencies/Commissions
  - Submit comments
  - Technical Experts
- AOTA and State Association Leadership
- Members

Understanding the Mysteries of Payer Reimbursement and Documentation
Why Medicare as a Model?
Medicare Basics
Part A
- Hospital inpatient services, SNF, home health, hospice, rehab facilities

Part B
- Physician services, hospital outpatient, durable medical equipment, orthotics, prosthetics, supplies

Part C
- Medicare Advantage, private insurance alternative to federal government’s Part A and B

Part D
- Prescription drugs

Medicare Terminology

CMS - Centers for Medicare & Medicaid Services
Transmittals / Program Memorandums
- http://www.cms.hhs.gov/Transmittals/01_overview.asp

CMS Online Manual System
- http://www.cms.hhs.gov/Manuals/IOM/list.asp

Prospective Payment System (PPS) (Part A)
Medicare rates set in advance based on expected resource use by patient
Medicare PPS rates
  - Time (per diem, per case, per episode)
  - Patient classification system (e.g., DRGs, RUGs)

Medicare Reimbursement under PPS
Prospective Payment System (PPS) (Part A)

Inpatient hospitals
- Diagnosis-related groups (DRGs)

Inpatient rehabilitation facilities (IRFs)
- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

Inpatient psychiatric facilities
- DRG rate based on diagnosis and other factors

Long-term care hospitals
- DRG system based on diagnosis and other factors

Medicare Reimbursement under PPS
Skilled nursing facility (SNF)
- Minimum Data Set
  - Resource Utilization Groups (RUGs)

Home Health
- Outcomes and Assessment Information Set (OASIS)
  - The OASIS gathers data on the patient’s discharge needs
  - Home Health Resources Group establishes payment

Hospice
- Payment rates are based on four categories: routine home care, continuous home care, inpatient respite, and general inpatient care.

Medicare Part B Physician Fee Schedule (MPFS)

CPT Coding
- Specific rate for a procedure
  - Based on time spent on a procedure, e.g. every 15 minutes of self care or
  - Untimed codes single flat rate per procedure per day, e.g. evaluation

Qualifying settings:
- Occupational therapist private practitioners
- Clinic, rehabilitation, agencies
- Hospital outpatient
- SNFs
- Physician office - Therapy incident to
- Home health care
- Comprehensive outpatient rehabilitation facilities
Documentation requirements
Medicare Coding Terminology Parts A and B

CPT - Current Procedural Terminology
☐ Bill methodology

CCI – Correct Coding Initiative (Medicare)
☐ Gate-keeping coding system

ICD-9 - International Classification of Diseases, 9th revision, Clinical Modification
☐ Diagnosis

ICD-9 Codes

CPT codes
☐ Timed and untimed codes
  ■ 8 minute rule
☐ Medically unbelievable edits
☐ CCI edits

CPT Codes - Procedures
Most rehab codes are in:
☐ Section:
  ■ Medicine
☐ Subsection:
  ■ Physical Medicine and Rehabilitation
☐ 97001 – 97755
  ■ OT eval 97003
  ■ Timed
☐ Ther Ex, ADLS, The Act
  ■ Untimed
☐ Group, several modalities

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Evaluation</th>
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</tr>
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<tbody>
<tr>
<td>97003</td>
<td>OT Eval</td>
<td>OT Evaluation</td>
<td>S</td>
</tr>
<tr>
<td>97004</td>
<td>OT Re-eval</td>
<td>OT re-evaluation</td>
<td>S</td>
</tr>
<tr>
<td>97016</td>
<td>OT Vasopneu Devices</td>
<td>Application of a modality to one or more areas; vasopneumatic devices (unattended procedure)</td>
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</tr>
<tr>
<td>97018</td>
<td>OT Paraffin Bath</td>
<td>Application of a modality to one or more areas; paraffin bath, (unattended procedure)</td>
<td>S</td>
</tr>
<tr>
<td>97022</td>
<td>OT Whirlpool</td>
<td>Application of a modality to one or more areas; whirlpool</td>
<td>S</td>
</tr>
<tr>
<td>97026</td>
<td>OT Infrared</td>
<td>Application of a modality to one or more areas; Infrared, (unattended procedure)</td>
<td>S</td>
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<tr>
<td>97032</td>
<td>OT Electrical Stim</td>
<td>Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes</td>
<td>T</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Details</td>
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<tr>
<td>97110</td>
<td>OT Therapeutic Ex</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
<td></td>
</tr>
<tr>
<td>97112</td>
<td>OT Neuromusc Re-Educ</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities</td>
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<tr>
<td>97140</td>
<td>OT Manual Therapy</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; manual therapy techniques (e.g., mobilization / manipulation, manual lymphatic drainage, manual traction)</td>
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<tr>
<td>97150</td>
<td>OT Therapeutic Group</td>
<td>Therapeutic procedure; group (2 or more individuals) (service based procedure)</td>
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<tr>
<td>97504</td>
<td>OT Ortho Fit &amp; Train</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; orthotics fitting &amp; training, upper and/or lower extremities and/or trunk</td>
<td></td>
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<tr>
<td>97530</td>
<td>OT Therapeutic Act</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; therapeutic activities is the use of dynamic activities to improve functional performance</td>
<td></td>
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<tr>
<td>97532</td>
<td>OT Cognitive Sk Dev</td>
<td>Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct one-on-one contact by the provider each 15 minutes</td>
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<tr>
<td>97533</td>
<td>OT Sensory Intgrat</td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct one-on-one contact by provider, each 15 min</td>
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<tr>
<td>97535</td>
<td>OT ADL Trn/Adp Equip</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; self care, home management training (e.g. activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology device / adaptations</td>
<td></td>
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<tr>
<td>97537</td>
<td>OT Comm Reinte</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; community/work reintegration training (e.g. shopping, transportation, money management, avocational activities, and /or work environment analysis, work task analysis, use of assistive technology devices / adaptive equipment) direct one-on-one contact</td>
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<tr>
<td>97542</td>
<td>OT Wheelchair Train</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; wheelchair management/propulsion training</td>
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<tr>
<td>97703</td>
<td>OT Ortho/Pros Ch Out</td>
<td>Checkout for orthotic/prosthetic use, established patient, direct one-on-one contact by provider, each 15 minutes</td>
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<tr>
<td>97750</td>
<td>Physical Performance Test</td>
<td>Physical Performance Test and Measures - (e.g., musculoskeletal, functional capacity, Berg, Tinetti) direct one-on-one contact by provider, MUST have written report, 15 minutes each</td>
<td></td>
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<tr>
<td>97755</td>
<td>Assistive Technology Assessment</td>
<td>Assistive technology assessment (e.g.; 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</td>
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</table>
ICD-9 (10) - Diagnosis - ICD-9 use a digit system

- **Section:**
  - Fractures (800-829)

- **Category:**
  - Fracture of upper limbs (810-819)
  - 813 Fracture of radius and ulna

- **Subcategory:**
  - 813.4 Lower end closed

- **Sub-classifications:**
  - 813.41 Fractures, Colles' fracture, closed

**Documentation Importance of Documentation**

1. Limited resources for health care have increased the need to justify in writing the necessity of OT and to distinguish OT from other therapy disciplines.
2. Our documentation needs to support the specific OT skills.
3. Payers can require focused medical reviews which add additional administrative time and effort.
4. Documentation has become a key component in making payment and coverage decisions.
5. Uniform billing and coding requirements have enabled payers to look at practice patterns and compare providers, identifying those outside the norm.

**Documentation**

Legal record
Communicate to others
Patient status
Clinical interventions
Justification of skilled services
Patient response to treatment and outcomes
Professional responsibility

**Medicare Requirements**

Why Medicare Part B – model for Medicare


- These standards are excellent for all Medicare settings

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) should also be used as reference. Available on Medicare Coverage Database.
  - http://www.cms.hhs.gov/med
General Conditions of Medicare Coverage
Under the care of a physician
Reasonable and necessary
Patient need for services
Qualified professional
Reasonable and Necessary
Expectation of improvement
Reasonable and predictable period of time
Typical amount, frequency and duration of services

Reasonable and Necessary
Patient’s medical complexity and need for services

Why the skills of a therapist are needed to perform these services
Specific and effective treatment for the patient’s condition
of a level of complexity and sophistication

Medical Necessity Factors include:
Diagnoses
Complicating factors
Age
Severity
Time since onset/acuity
Self efficacy / motivation
Cognitive ability
Prognosis
Stability of the condition: medical, psychological and social stability

Reasonable and Necessary
Continued justification in evaluations and monthly summaries

Medical Necessity

“Patient’s progress continues to be steady but slowed due to her increased fatigue related to reoccurring respiratory issues (bronchitis). She is experiencing difficulty with movement due to her obesity. Both conditions further complicate her COPD, requiring frequent rest breaks and shortened treatment sessions.”

“This week, progress has been slowed due to the development of swelling and pain (8/10) in the left hand resulting in decreased ability to use his hand in functional activities. Patient was diagnosed this week with Complex regional pain syndrome (RSD) and plan of care has been modified to include treatment of the symptoms including modalities (name the modality) and positioning strategies, as well as medication ordered by his physician.”
Skilled Therapy Required
Services must have the level of complexity and sophistication that only a therapist/assistant is qualified to provide them.
☐ The skills of a therapist/assistant are necessary to meet client’s need.

We need to link how our services are specialized and required.

Skilled Therapy Improved
“Patient is s/p recent CVA (6/1/08) resulting in right UE/LE hemiparesis, apraxia and dysphagia. Patient would benefit from skilled OT treatment for hemi-technique self care retaining, neuromuscular reeducation, graded UE strengthening, motor function treatment (motor control, motor learning and perceptual motor activities) and postural stability intervention to improve functional balance for self care activities and safety in order to return home.”

Tips for Successful Documentation
1. Expectation of Improvement
2. Reasonable and predictable period of time
3. Typical amount, frequency and duration of services
4. Patient’s medical complexity and need for services
5. Why the skills of a therapist are needed to perform these services

Types of Documentation
Evaluation
Goal Writing
Daily Treatment Notes
Progress Notes
Monthly Summary
Discharge Summary

Evaluation
Include patient demographic information

The Evaluation has Four Components:
1. Decline in function.
   ✓ Document the diagnosis/diagnoses and specific problems to be evaluated.
   ✓ Document the client’s prior level of function.
   ✓ Document any complicating conditions (diabetes, RA) that may impact treatment (describe why or how).
2. Objective measures.
   ✓ Identify baseline function to measure future performance outcomes.
   ✓ Document the link between tests, measures, clinical judgments and the client’s function.
3. Reasonable and necessary skilled service.

4. Qualified personnel providing services.

**Prior Level of Function**
“Pt lives alone in Sr. complex apartment (dinner provided). Prior to her CVA, she was ambulatory, independent in all self-care and light meals; she had a helper who cleaned, did her laundry and shopped for her.”

**Objective Measures**
CMS has suggested using one of four measurement instruments when evaluating and assessing patient progress:
- National Outcomes Measurement System (NOMS)
- OPTIMAL
- Patient Inquiry Tool by Focus on Therapeutic Outcomes, Inc. (FOTO)
- Activity Measure for Post Acute Care (AM-PAC)

**Other Options**
Documentation to include functional assessment scores or other measurable progress toward goals.

CMS has made three alternative suggestions.
- Commercially available functional assessment
- Tests and measures published in professional literature
- Documented measurable progress toward goals for the patient to function in his or her home environment.
  - Level of Independence Scales
  - Independence – level of assistance - dependent
    - Bladder diary

**Objective Tests and Measures**
- Goniometric ROM Measures
- Manual Muscle Test (MMT)
- Kohlman Evaluation of Living Skills
- Functional Reach Test Scores
- Loewenstein Occupational Therapy Cognitive Assessment (LOTCA)
- Canadian Occupational Performance Measure, (COPM)
- 9 Hole Peg Test
- Purdue Dexterity Test
- Minnesota Rate of Manipulation Test (MRMT)
- O’Connor
- Grip/Pinch
- Motor-Free Visual Perception Test (MVPT)

Last option:
- Patient’s opinion on his/her health related to quality of life.
  - “At the present time, would you say that your health is excellent, very good, fair or poor?”
Objective Tests and Measures

**Document the link between tests, measures, clinical judgment and the patient’s function.**

- “The patient scored average of 8 inches in three trials on a Functional Reach Test. As evidenced in the functional reach test, the patient has decreased balance. Based on these results, he has 2 times the normal risk for multiple falls.”

**Document status at discharge.**

**Example**

“Patient’s right bicep strength is graded 2/5. With is level of strength, the patient is unable to flex his arm against gravity. This type of motion would be necessary for him to ....... (e.g., feed himself, participate in oral care, or use a grab bar during bathroom transfers).”

**Goal Writing**

**Who**
- Will do what
  - Quality of the action
  - Under what circumstances
    - By when

**Goal Writing**

Who
- Resident, caregiver or family member
- Not the therapist

What
- Action task or activity

Quality of the action
- Measurable action, accuracy, frequency, duration

Under what circumstances
- Conditions under which actions occur

By when
- Target date for goal to be achieved

Poor: “Min A with self care”
Better: “Patient will don his upper body using one-handed hemi- techniques with minimal assistance and verbal cues (may state number of VC) during morning ADLs by 1/10/12.”
Tips for Successful Documentation  Four Components to the Evaluation:

1. Decline in function
2. Objective measures
3. Reasonable and necessary skilled service
4. Qualified personnel providing services

Ongoing documentation

• Daily Treatment Note

• Progress Report

Daily Treatment Note

Record daily services delivered

☒ Date of treatment

☒ The services delivered in CPT codes
    ■ Time and units

☒ Name/credentials

☒ Document unusual or unexpected occurrences

☒ Payer or state practice acts requirements

Progress Notes

Frequency depends on practice setting:

☒ Weekly Progress Note

☒ Monthly Summaries

Discharge Summaries / Progress Notes

Justifies the medical necessity of treatment by stating the relationship of skilled service to client’s outcomes-why we make a difference.

• Provides objective evidence that the client’s anticipated improvement is attainable in a reasonable period of time.

• Identifies how current functional performance is different from previous performance for each identified goal in objective measurements and comparative statements.

Depending on the setting may be the same as a treatment note.
**Weekly Progress Notes Examples**

“Patient is demonstrating improved tolerance and performance during showering activity. OT provided instructions for energy conservation, work simplification, purse-lipped breathing techniques and how to use the Rate Perceived Dyspnea (RPD) for self monitoring the activity. This week she did not demonstrate any SOB, her blood pressure remained within specified parameters of 120/84 – 140/90 and herself report for dyspnea was improved from a rating of ‘4’ (severe difficulty) last week to a rating of ‘2’ (some difficulty) this week.”

**Examples Weekly Progress Notes**

“Patient was able to successfully don and doff shirt with minimal assist after completion of skilled program of graded upper extremity strengthening exercises.”

**Monthly Summary**

Summarize the patient’s functional status
Justify medical necessity to continue treatment
Need for skilled therapy services
Update goals and treatment plan

**Discharge Summary**

Similar to a monthly summary
Includes objective measurements and comparative statements from the evaluation to the time of discharge
“The skills of a therapist were necessary for… (list reasons).”
Recommendations for follow-up, home programs and referrals
Justify medical necessity, especially if services extend beyond customary length of time
****Last chance to communicate your skilled services

**Review**

• Initial evaluation
• Goal Writing
• Treatment note
• Weekly progress note
• Monthly progress note
• Discharge summary

**Successful Documentation**

1. Expectation of improvement
2. Reasonable and predictable period of time
3. Typical amount, frequency and duration of services
4. Patient’s medical complexity and need for services
5. Using objective tests and measures to validate findings.
6. Why the skills of a therapist are needed to perform these services
7. Types of documentation and related key elements
Our Responsibility

View documentation of service as important as the intervention we provide.

Communicate why the skills of a therapist are needed.

- Keep a library of evidence based resources
- Know what the standard of practice is for your practice or the patient’s diagnosis

Prevent nonpayment or ending of services because of inadequate skilled documentation.

Know the requirements of our payers and understand your payer’s payment policies

- Use your payer’s language in your documentation

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