Part B Insider (Multispecialty) Coding Alert

Part B Statistics: Measure Your Physical Therapy Claims Against Your Peers

Hint: Clear and concise documentation alleviates many coding issues.

Ever wonder how your practice Part B claims stack up? A new Comparative Billing Report (CBR) from Palmetto GBA has the details to help you figure out how you compare to other physical therapists.

Background: In its CBR released March 29, Part B MAC Palmetto GBA focused on claims issues, trends, and benchmarks that the payer has seen for Medicare providers who practice physical therapy (specialty 65). Palmetto initiated the analysis "because the OIG has found that Medicare spending for outpatient therapy was 72 percent higher in some areas of the country than the national average," the CBR report said in its "Frequently Asked Questions" section. "Additionally, the OIG determined that outpatient services provided by independent physical therapists were not always reasonable and medically necessary and/or were not documented properly."

Remember: The feds use CBRs as a tool to offer insight into billing and coding trends across different specialties and healthcare settings. CMS partners with its contractor eGlobalTech to produce the reports, which you can find at www.cbrinfo.net. You can use this timely data from Palmetto GBA's CBRs to see where you stand when it comes to the frequency of billing certain services, codes, or modifiers and more importantly, utilize these peer measurements to eradicate your practice coding problems.

Take a Look at the CBR Specifics

The OIG found in the 2010 report, Questionable Billing for Medicare Outpatient Services, "that physical therapists in some parts of the country appended modifier KX more frequently than physical therapists in the other parts of the country," said **Tamara Canipe, RN**, clinical quality management coordinator with Palmetto GBA, during a webinar explaining the CBR's findings. And this "higher utilization" was 72 percent higher than the national average, suggested Canipe, leading to the need for the CBR. See the Questionable Billing for Medicare Outpatient Services report at: https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf.

Focus area: The Medicare Fee-for-Service information used in the report came from physical therapy claims appending modifier GP for dates of service between July 1, 2015 and June 30, 2016. The CBR team looked at the data of "approximately 15,000 physical therapists in private practice, who had different billing patterns compared to their peers," noted **Cheryl Bailey**, senior consultant with eGlobalTech, in the webinar. In addition, "each recipient of CBR 201702 has at least 50 beneficiaries and $30,000 in allowed charges for the CPT® codes included in the CBR and is significantly higher in at least one of the measures calculated in the CBR," the report FAQ mentions.

The following codes and modifiers were reviewed and analyzed in the CBR:

CPT® Codes

- **Deleted code 97001** (Physical therapy evaluation)
- **Deleted code 97002** (Physical therapy re-evaluation)
- **97035** (Application of a modality to 1 or more areas; ultrasound, each 15 minutes)
- **97110** (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)
- **97112** (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities)
- **97140** (Manual therapy techniques [eg, mobilization/ manipulation, manual lymphatic drainage, manual

traction], 1 or more regions, each 15 minutes)
- **97530** (Therapeutic activities, direct [one-on-one] patient contact [use of dynamic activities to improve functional performance], each 15 minutes)

HCPCS Code and Modifiers

- **G0283** (Electrical stimulation [unattended], to one or more areas for indication[s] other than wound care, as part of a therapy plan of care)
- **GP modifier** (Services delivered under an outpatient physical therapy plan of care)
- **KX modifier** (Requirements specified in the medical policy have been met)

Reasoning: The report targeted three areas of concern within physical therapy billing. First, they looked at the use of the KX modifier because it "indicates that the services are at or above the therapy caps. This metric was designed to focus on providers billing this modifier at rates above their peers," said **Steve Ash**, a statistical » analyst with Palmetto GBA. He added, "Although adding the modifier is justifiable, the percentage of beneficiaries needing additional care should be comparable across all providers in the peer groups." Other focus areas included the Average Minutes Per Visit and the Total Allowable Charges Per Beneficiary.

Stats: According to the CBR research, the national provider averages for the use of KX modifier were around 21 percent while the median Average Minutes Per Visit was at 45.67 percent. The average Total Allowable Charges Per Beneficiary came in at $724.03 nationally.

Outline a Plan of Care and Document Your Findings

The lack of medical necessity and poor documentation contributed to the need for Palmetto's CBR and data. Consider revising your policies and procedures to avoid outlier tendencies.

Plan of care tips: Whomever is furnishing the therapy services must write a plan of care that's consistent with the evaluation. The plan should contain a diagnosis, long-term treatment goals (which should be measurable) and the type of treatment you're rendering, whether it's PT, OT, or speech language pathology. You also must indicate the amount (the number of times a day it will be done), the duration (the total number of weeks or treatment sessions) and the frequency (the number of times in a week), which may taper as the patient progresses in treatment.

The person who creates the plan of care should sign and date it. If any changes are made to the plan of care, it should be signed and dated with the adjustments. A therapist may not alter the plan of treatment established/certified by a physician or non-physician practitioner without their documented written or verbal approval.

Reminder: Your records should include progress reports at least every 10 visits that include the PT's assessment of improvement, progress, plans for continuing treatment, changes to goals, and functional documentation. In addition, treatment notes for each date of service must outline the treatment dates, which modalities were performed, individual service minutes and total treatment minutes, and the provider's signature.

If your documentation is missing any of these elements, your MAC could and will demand that you return any reimbursement you've received for the services in question. Therefore, documenting all of your encounters should be just as important as billing for them.

Check Your Numbers

If you think your claims data suggests that your billing rates are "significantly higher" than your peers, benchmark your practice averages against those of other physical therapists. To find out how often you use the KX modifier compared to others, divide the number of beneficiaries serviced with the KX modifier appended then divide that by the number of total beneficiaries you see and multiple that number by 100, the CBR report advises. Check your stats against the national averages from Palmetto's CBR.

Minutes and charges: The easiest way to find time spent with your patients is to multiply the Allowable Services under the CBR's chosen CPT® codes by 15 minutes, then divide that by the total number of visits. To access your Allowable

Charges Per Beneficiary information, divide your total allowable charges by the number of beneficiaries, the CBR suggests.

State results: The top three states with the highest Allowable Charges Per Beneficiary were the District of Columbia at $941.42, New York at $914.98, and New Jersey at $908.45.

Tip: Once you run your reports, use the data that you glean from them to plug numbers into the average benchmarking calculations and you're on your way to creating a system-wide benchmarking program for your physical therapy practice.

Resource: To review Palmetto GBA and eGlobalTech's CBR 201702, visit https://www.cbrinfo.net/cbr201702.