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# Eli's Rehab Report

## Coordinating Care Is Key When Coding Therapy for Prosthetics Patients

Because treating amputees involves numerous medical caregivers, some coders are confused about how to bill for so many services simultaneously. Prosthetic care requires very careful monitoring of how the claims are written because it necessitates coordination between all of the physicians and therapists involved. For instance, a 62-year-old female patient suffering from diabetes mellitus has her left lower leg (below the knee) amputated. Postoperatively, the patient goes home to recuperate until her surgeon determines that the wound and bone are healing well, and refers her to a physiatrist for a full rehabilitation course.

The physiatrist examines the patient and brings in a physical therapist (PT) to help evaluate her condition. The PT performs an evaluation and, along with the physician, writes a plan of care for the therapy services. The patient has already been fitted for a prosthetic lower leg, so they ask her to return at the end of the week to receive it.

The practice would bill the appropriate E/M code for the patients visit. Assuming the physiatrist had not seen the patient before, the evaluation would be a new patient visit (99201-99205) and not a consultation (99241-99245) because the patient was referred to the physiatrist to take over the rehabilitation care, says **Laureen Jandroep, OTR, CPC, CCS-P,** owner of A+ Medical Management and Education, a coding and reimbursement consulting firm and a national CPC training curriculum site in Egg Harbor City, N.J.

It wouldnt be a consult unless the surgeon simply asked the physiatrist for his or her opinion on the patients rehabilitation, says Jandroep. If the surgeon turns the patients rehabilitation care over to the physiatrist, the physiatrist would bill it as a new patient. It is very likely that the surgeon is still seeing the patient somewhat regularly as part of the global surgical care to ensure that the wound and bone are healing properly, but the physiatrist could bill separately for the rehabilitation care, assuming the insurer allows that type of arrangement.

Jandroep says this is a perfect example of the merits of precertifying patients before they come into the office. When the surgeon refers the patient to your practice, ask the insurer what type of rehabilitation care is allowable and whether there are any utilization or time limitations on it. Its important to know this ahead of time so you can prepare an advance beneficiary notice, if necessary, for any services that may not be covered.

The PTs evaluation is billed using **CPT 97001** (physical therapy evaluation), but writing the patients plan of care is not separately billable, as it is included in the code.

**Physical and Occupational Therapy Begin**

When the patient returns later in the week, the PT first teaches the patient how to use the prosthetic, says **Elaine Brexel, PT,** a physical therapist and satellite manager of East Cobb Rehabilitation, a division of Childrens Healthcare of Atlanta, which provides pediatric rehabilitation services in Marietta, Ga. We would then move from prosthetic-training into weight-bearing exercise, knee extensions and therapeutic exercise and, from there, onto gait-training. But these wouldnt all normally occur on the same day.

The patients prosthetic training is billed using 97520 (prosthetic training, upper and/or lower extremities, each 15 minutes). Most insurers require additional documentation for prosthetic training that continues for more than three months, since the majority of patients are comfortable using their prosthesis by that point. If the therapist also began weight-bearing exercises the same day, that service would be billed using either the therapeutic procedure code, 97110 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) or 97112 ( ... neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception), depending on which service most accurately reflects which types of exercises are

involved.

Once the patient is comfortable putting weight on the prosthesis, the therapist begins teaching the patient how to walk, climb stairs, sit and stand with the new leg. Walking and stair-climbing would be billed using 97116 (... gait training). Most insurers will reimburse for gait-training between three and seven times per week for amputees, so there is a wide variation in what is allowable.

At this point in the patients care (or sometimes sooner), the occupational therapist (OT) would evaluate how the patient can adjust to her new condition more easily. The OT would bill for his or her evaluation (which, like the PTs evaluation, must be requested or ordered by the physician) using 97003 (occupational therapy evaluation). The OT would then begin training the patient to perform such tasks as bathing or dressing using the prosthetic leg. This frequently falls under 97535 (activities of daily living), although OTs often perform therapy services such as gait-training, prosthetic-training and therapeutic exercises as they relate to activities of daily living, such as entering or exiting a car. This is usually determined when the therapists and the physician write the treatment plan and coordinate care with one another.

**If a Problem Arises**

Several weeks into the patients therapy, she presents to the physiatrist for a normal follow-up evaluation, but complains of pain in her thigh. The exercises she has been performing at home at her therapists request have caused muscle strain in the thigh of the leg where the lower-leg amputation took place. The physician advises the patient to perform only the exercises as directed, as he has determined that she has been overdoing her exercise plan. He gives the patients chart to the biller, who is unsure how to bill the diagnosis.

Because she has been billing for services due to a left leg amputation, she doesnt know whether to bill for muscle strain in the left leg, assuming that the insurer will believe that an error has occurred. However, you should code for thigh strain on the left leg because thats what the patient had. Since you have probably made clear by this point that the amputation was of the lower left leg only, the insurer should understand what happened, says Jandroep. Because the code for leg strain is 844.8 (sprains and strains of knee and leg; other specified sites of knee and leg), which is a nonspecific code, you may receive a denial. If so, you should appeal the claim and send it in with documentation identifying the thigh strain as the reason for the visit.

Because two-thirds of all amputations occur as a result of vascular diseases, such as diabetes, there are often even more clinicians involved in a patients care, beyond therapists, surgeons and physiatrists. Be sure to coordinate billing with all of the physicians involved in the patients care to ensure that no two clinicians are performing duplicate services. If, for example, the patient were receiving physical therapy from both the surgeon and the physiatrist, the insurer could reject the physiatrists claims, so its important to know exactly who is performing which of the patients services.

If the therapy services are billed incident to using the physicians identification number, be sure the physician is on the premises and that all of the requirements of incident to billing are met.

All documentation for therapy should note precisely the time devoted to each therapeutic treatment, the person who provided the care and each modality. In addition, the patients chart should include a copy of the current treatment plan with signatures of the supervising physiatrist and therapist. Documentation must also include the date the physiatrist last saw the patient. As most practices know, the referring physician must sign off on the patients therapy treatment plan, which must be on record and reviewed and signed by the physician every 30 days.